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ABSTRACT

This manual is designed to be used for "Administrative Aspects of Occupational Medicine," one of two officer correspondence courses offered by the Naval Medical Training Institute. Part one comprises guidelines for setting up occupational health clinics, covering the areas of staffing, layout, equipment, other services, and records maintenance. Part two covers clinic routine and staff responsibilities; part three describes standing orders for nursing staff; part four contains samples of the Bureau of Employees' Compensation standard form, the Civil Service Commission forms, and others most likely to be used in occupational health programs. The firnal section provides selected references in the field, a reference list of official publications, selections from the Federal Personnel Manual, a list of national organizations concerned with occupational health, and an index. The orientation of the manual is toward those working in military installations but it could be used by anyone setting up an occupational health clinic. (SA)

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OCCUPATIONAL HEALTH MANUAL

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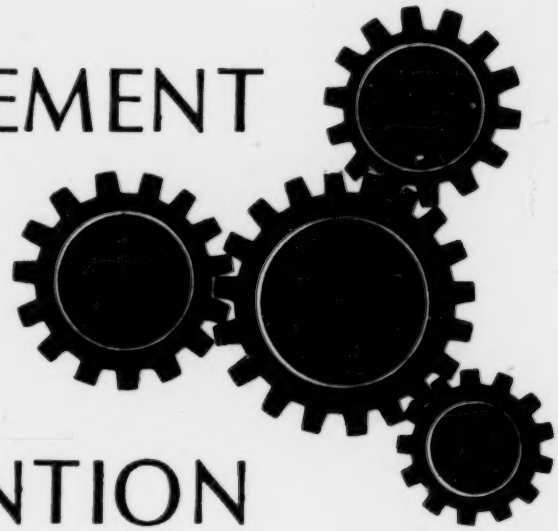

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NAVAL MEDICAL TRAINING INSTITUTE
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PREFACE

This *Occupational Health Manual* will be used as the text for "Administrative Aspects of Occupational Medicine," one of two officer correspondence courses on occupational medicine offered by the Naval Medical Training Institute. It describes basic administrative procedures essential to smooth operation of an occupational health program. The professional aspects of occupational medicine are covered by *Occupational Diseases: A Guide to Their Recognition* (Public Health Service Publication No. 1097), the text for the companion course "Technical Aspects of Occupational Medicine."

The present interest in ecology and public awareness of industrial pollution endangering man and his environment have spurred development of these courses on occupational medicine. The appearance of new substances, new uses of common materials, and continuous changes in industrial processes all contribute to increased industrial pollution. Though these factors, directly or indirectly, affect the health of the general population, they are even greater hazards to the health of the industrial population. Frequently, the occupational origin of industrial disease escapes detection, and health impairments may not be noticed for months or years. There should be no letup in monitoring for toxic, chemical, biological and physical pollutants of the environment.

This manual is the result of much cooperation between the Naval Medical Training Institute, and related divisions at the Bureau of Medicine and Surgery who also provided valuable technical guidance. Much of the information here is based on an unpublished preceptor handbook *Manual of Occupational Health* prepared by Dr. William A. Redman for use at the Naval Ammunition Depot, Naval Ordnance Systems Command, at Crane, Indiana. We are indebted to CDR E. J. Sullivan, MC, USN, of the Naval Industrial Environmental Health Center for preparing the present manuscript and updating the information.

We commend the following members of the Naval Medical Training Institute staff for contributions as follows: Captain D. H. Gaylor, MC, USN, for overall direction of the task; LCDR D. J. Egan, MSC, USN, and HMC E. M. Staples, USN, for course development information support; the Medical Photography Division for the photographic work; HM3 M. A. Willhoite, USN, for cover design; and Mrs. Elsie C. Yuen, writer-editor, for the editorial work.

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June 1972

DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
WASHINGTON, D.C. 20390

IN REPLY REFER TO
BUMED-73-GML:dkh

Dear Doctor

You are stepping into an exciting professional challenge. You now have the responsibility for the health of all the employees of your activity and some responsibility for the health of the surrounding community.

When you see an employee, you must consider how the total work environment affects his health, how his health problems affect his fellow workers, and how his health problems affect the health of the community in which he lives. Moreover, you may need to consider how the industrial processes occurring on your station affect the well-being of surrounding communities.

To assess the impact of the work environment of the employee, you will need to visit regularly each industrial setting looking for chemical, biological, mental health and physical problems including mechanical hazards. It is next to impossible to diagnose an occupational illness without having visited the worksite and knowing the materials and processes involved.

When the worker comes to you, this is the time to consider how his health problems affect his fellow workers and the people in his community as well as how his health is affected by the work environment.

You will find that personnel in the Safety Department and the Civilian Personnel Department are able and willing to help you find the most effective way to solve problems that occur in the Occupational Health Program on your station. Should you need or want additional assistance on occupational health problems, the Navy Industrial Environmental Health Center staff is available for consultation by telephone, letter, or visit.

Sincerely yours,

George M. Lawton

GEORGE M. LAWTON, CDR, MC, USN
Director, Industrial Environmental
Health Division

CONTENTS

Part One—Introduction to an Occupational Health Program 1

Purpose 1

Organization of an Occupational Health Clinic 3

Personnel 3

Clinical Facilities and Equipment 3

Layout and Space Allocation 4

Staff and Patient Conveniences 4

Special Treatment Rooms 4

Adequacy of Clinic Facilities 4

Planning and Construction 5

Medical Equipment 5

Night Service 6

Other Services 6

Records Maintenance 7

Routine Instructions 7

Handling of Medical Information 8

Cooperation with Other Resource Groups 8

Command and Civilian Personnel 9

Safety Department 9

Civil Service Commission 9

Navy Industrial Environmental Center 11

Private Physicians 11

Local State and National Organizations 11

Part Two—Clinic Routine and Staff Responsibilities 13

Reception and Records Clerk 13

General Requirements 14

Other Office Duties 14

Reception Desk Duties 14

CONTENTS–Continued

Keeping a Daily Log 15
Pre-hire Examination Routine 15
Keeping Health Records 15
Preparing/Filing Compensation Forms 18
CA 1&2 Notice of Injury 18
CA 1&2 Supervisor's Report 18
CA - 16 Referral 18
CA - 16 Referral to Private Physician 19
CA - 2a Notice of Recurrence of Disability 19
Disposition of Other Records and Reports 19
Monthly and Quarterly Reports 19
Medical Followup Cards 19
Correspondence 19
Medical Records of Applicants Not Employed 19
Repeat Audiogram Log 20
Confidential Medical Reports 21
Nursing Staff 21
Administrative/Supervisory Duties 21
General Nursing Duties 21
Preparing Patients for Examination by Physician 22
Post-Examination Followup 22
Continuing Self-Education and Health Promotion 22
Health Evaluations 23
Pre-Hire Examinations 23
Periodic Health Evaluations 24
The Occupational Health Physician 25
Work Environment Orientation Duties 26
Emergency Care Duties 27
Treatment of Occupational Conditions 27
Handling Compensation Cases 27

CONTENTS–Continued

Humanitarian Treatment 27
Differentiating Between Occupational and Non-Occupational Injuries 28
Recording Clinical Data 28
Reporting Occupational Condition 28
Consultation with the Safety Department 29
"On-the-job" First Aid 29
Care of Military Dependents and Retirees 29
Physical Examinations 29
Examination of Applicants for Light Duty Work 30
Pre-Hire Examinations 30
Routine Preliminary Tests and Repeats 30
Examination Report Procedure 33
Special Problems 35
Post-Physical Recommendations 35
Periodic Health Evaluations 36
Fitness-for-Duty Examinations 37
Disability Retirement Examinations 40
Other Special Examinations 41
Placement of Women Who Work 41
Determination of Employee Fitness 43
Administering the Annual Health Program 43
Health Education and Counseling 43

Supplemental Information for Physicians 44
Industrial Hygiene and Occupational Diseases 44
Role of the Industrial Hygienist in Occupational Environmental Control 45
Surveys and Samplings 45
Hazards Control 45
Sight Conservation Program 46
Eye Care and Working in Hazard Areas 46
Contact Lens Use in the Work Area 46
Hearing Conservation Program 47

CONTENTS Continued

The Audiometric Examination 47
Noise Measurement and Engineering Control 48
Noise Attenuation with Protective Devices 48
Employment of the Handicapped 48
Workmen's Compensation 49
Administrative Problems of Physically Unqualified Employees 50
Forms to Use for Reporting Medical History 50

Part Three—Standing Orders for Nursing Staff 51

General Emergency Procedures 53
Bleeding Control 53
Resuscitation 53
Shock Prevention and Treatment 54
Prevention of Wound Infection 54
Care of the Unconscious Patient 55

Tentative Standing Orders for Specific Conditions 55
Abrasions 55
Animal Bites 56
Arthropod Stings and Bites 56
Snake Bites 58
Thermal Burns 58
Chemical Burns 59
Cardiac Emergencies 60
Dermatitis and Skin Problems 61
Dysmenorrhea and Other Gynecological Problems 61
Earache 62
Live Insect in Ear Canal 62
Other Ear Problems 62
General Procedures for Eye Injuries 63

CONTENTS–Continued

Burns of the Eye 63
Contusions of the Eye 65
Eye Pain 65
Foreign Body in the Eye 66
Other Eye Injuries 67
Vision Problems 68
Headache and Fever 68
Heat Disorders and Emergencies 68
Lacerations 70
Musculoskeletal Injuries 71
Nosebleed or Nose Injury 73
Respiratory Infection 73
Toothache 74

General Procedures for Occupational and/or Non-Occupational Disorders 74
General Procedures for Death and Serious Injury 75
Convenience Treatments Authorized by Private Physician 75
Immunizations 76
Detection of Emotional Problems 77

Part Four–Sample Forms 79

Bureau of Employment Compensation (BEC) Forms 79
CA 1&2: Federal Employee's Notice of Injury or Occupational Disease 84
CA-2A: Notice of Recurrence Of Disability 88
CA-16: Request for Examination and Treatment 90

Standard Forms (SF) 92
SF-78: Certificate of Medical Examination 92
SF-177: Statement of Physical Ability for Light Duty Work 95
SF-93: Report of Medical History 99

CONTENTS–Continued

SF 71-109: Application for Leave 101
SF 2801-B: Physician's Statement in Connection with Disability Retirement ... 102

Civil Service Commission (CSC) Forms 104

CSC Form 740: Eye Examination 104
CSC Form 739: Medical Report (Epilepsy) 106
CSC Form 3684: Medical Report (Diabetes Mellitus) 107
CSC Form 4434: Medical Report (Pulmonary Tuberculosis) 108
CSC Form 3986: Authorization for Release of Medical Records 110

Other Forms 111

Optional Form 58: Report of Medical History 111
NAVSO 5100/9: Dispensary Permit 113

Local Forms and Letters 114

Cardiac Followup Sheet 114
Diabetic Followup Sheet 115
Health Evaluation Procedures 116
Humanitarian Emergency Care 117
Letter to Physician for Confirmation of Pregnancy and Advisability of Continuing Work 118
Medical Followup Card 118
Occupational Injury or Illness Report 119
Physiotherapy Prescription and Record 120
Request for Information from Physician 121
Request for Information on Employee Following Recovery from Heart Attack ... 122
Request for Information on Employee Returning to Light Duty 123

Part Five–References

Selected References 125

Reference List of Official Publications 127

FPM Selected Chapter Listings 129

FPM Chapter 792 133

FPM-792 Letters and Attachments 140

National Organizations Concerned with Occupational Health 187

Index 189

PART ONE

INTRODUCTION TO AN OCCUPATIONAL HEALTH PROGRAM

PART ONE

INTRODUCTION TO AN OCCUPATIONAL HEALTH PROGRAM

Purpose, 1

Organization, 3
- Personnel, 3
- Clinical Facilities and Equipment, 3
- Night Service, 6
- Other Services, 6
- Records Maintenance, 7

Cooperation with Other Resource Groups, 8
- Command and Civilian Personnel, 9
- Safety Department, 9
- Civil Service Commission, 9
- Private Physicians, 11
- Local, State and National Organizations, 11

PURPOSE

To increase or maintain production in our industrial society today, efficient worker performance of assigned duties is essential. It is to maintain this health fitness in the worker that occupational health programs are designed. Such a program applies public health principles, and medical, nursing, and engineering practices to conserve, promote and restore the health of workers. Achieving this through the workers' places of employment is what distinguishes an occupational health program from other preventive medicine programs.

However, since the total industrial environment determines an industrial worker's worth and output as an employee, he may become less interested and satisfied with his work when production lines and methods become more automated. His home and family problems and interpersonal conflicts may also contribute to lower efficiency. Also, the changing nature of the work force—more women, and proportionately more white than blue-collar workers—brings added problems. Because of this, all available health and social services need to work together in a program to

promote employee health fitness. Though the program is primarily employee-oriented, many spinoff benefits accrue to management.

Labor turnover, absenteeism, and liability compensation for occupational illness and injury are items of major expense to business and industry, and reductions in their occurrence may be considered as management benefits. Therefore, in a broad sense, a well-run occupational health program which stresses employee health fitness also keeps these occurrences to a minimum. This may be achieved by:

- Maintaining a healthful work environment
- Health examinations
  - ☐ Pre-employment physical examination to aid placing an employee in work for which he is physically and emotionally qualified
  - ☐ Periodic health evaluations to insure that the worker continues able to handle his job, and to encourage him to remain in good health and seek early treatment for minor non-disabling conditions.
- Providing emergency medical care for
  - ☐ Occupational injuries and illness, and
  - ☐ Non-occupational conditions, to keep the worker on the job if possible, or to refer him to his own physician when further care is required.
- Practice of preventive health through
  - ☐ Education
  - ☐ Immunizations
  - ☐ Surveys designed to reveal chronic conditions and promote early treatment
  - ☐ Counseling on health, social, and family problems.

Since a wide range of duties and service is involved to attain these goals, information applicable to operating a well-run occupational health program will be incorporated here into a single reference source for the Medical Officer and the occupational health staff. The concept of occupational health, and the administrative procedures and standing orders for treating occupation-incurred illness and injuries presented here are in accord with current medical practice and standards established by the AMA Council of Occupational Health. They are also compatible with pertinent regulations as set down in the *Federal Personnel Manual* and the Federal Employees' Compensation Act.

Medical Officers* are advised to review carefully the standing orders (pp. 51-77), make such changes as advisable, then attach signature to implement these instruc-

*The designations "medical officer" and "physician" are used interchangeably here. Unless qualified otherwise, they refer generally to the occupational health physician. The terms "industrial" and "occupational" are also used interchangeably as are "dispensary" and "occupational health clinic."

tions. Any in-house procedural variation and additional information should be clearly identified as such. Information on local resources will be updated as needed. See "Physician Approval of Standing Orders," p. 52, and "Local Resource Information," p. 9.

ORGANIZATION OF AN OCCUPATIONAL HEALTH CLINIC

Personnel

Many guidelines have been suggested to determine the number of personnel required to staff an occupational health clinic. These useful guides are all based on the number of employees, but equally important are other purely local factors, such as types of industrial hazard, availability of other medical facilities, number of shifts working, and inclusion or not of dependents served.

Essentially, the clinic staff should include a physician who is in charge, a registered nurse who supervises the rest of the personnel, and a reception and records clerk. For a clinic serving less than 300 employees, a full-time registered nurse and a part-time physician may be adequate. But, for 1,000 or more employees, a full-time physician is desirable, and he may serve as many as 4,000 employees, unless they are engaged in hazardous work. Additional nurses are recommended at one per 1,000 employees.

The physician should organize the clinic so that routine matters can be handled smoothly and efficiently. His closest relationship will be with the occupational health nurse (or chief nurse, if there is more than one nurse) who must know the "ground rules" and sources of information, as well as her own professional field. His instructions to her should provide simple, but precise directions for medical emergencies.

As the chief assistant to the occupational health physician, an experienced and dependable nurse is the key to the well-functioning clinic. In small establishments, the nurse may take on additional duties of a reception and records clerk. A relief nurse should also be available.

Services of laboratory and X-ray technicians, if available on premises, should be adequate for all routine work required. However, a full-time combination laboratory/X-ray technician on the occupational health clinic staff is indicated if the work force exceed 1,000; for a work force over 1,500, a full-time technician for each specialty may be needed.

Clinical Facilities and Equipment

In checking the adequacy of existing facilities and equipment available for an occupational health clinic, several considerations should be kept in mind.

Layout and Space Allocation

The clinic layout should be adequate for examining, treating, and testing patients, and should contribute to a functional use of space, a logical traffic-flow pattern, effective staff operation, good patient privacy, and an attractive appearance and relaxing atmosphere.

Functional use of space is important since supposedly adequate space poorly distributed can be quite unsatisfactory. A general rule of thumb suggests that total floor space for the clinic be calculated at a rate of 100 to 150 square feet for each 100 employees, with a waiting room space averaging 30 square feet allowed for each person waiting. These rough approximations may be helpful to determine if problems exist.

The traffic flow should be channelled in such a way that waiting patients are relatively undisturbed until called. It should be possible for acutely ill or injured patients to enter and leave without going through the waiting room.

Staff and Patient Conveniences

To promote a smooth-running clinic operation, conveniences for both staff and patients should be considered. Privacy for patients undergoing tests and interviews is a major necessity, as are separate and adequate toilet facilities for both men and women. These should be located to facilitate processing of urine specimens.

An adequate number of examining rooms should be available, each with the necessary diagnostic equipment and handwashing facilities. At least one bed for limited rest or observation, and used for no other purpose, is highly desirable.

Special Treatment Rooms

Space will also be needed for electrocardiography and physiotherapy. It is helpful, especially if the examining area is limited, to have several dressing rooms.

Perhaps the factor most subject to change, and also most often missing in the waiting rooms is an attractive appearance. Racks should be provided for magazines and health education materials. Plants or flowers may add to the appearance and help create a relaxing atmosphere.

Adequacy of Clinic Facilities

If there is any question on the adequacy of clinic facilities, consult the senior medical officer of the activity. The plant public works officer may be of help. Problems concerning clinic facilities should be discussed during occupational health surveys.

Planning and Construction

New occupational health clinic facilities are planned only by higher authority in accordance with Department of Defense policies. However, it is possible tc alter, modernize, or replace existing facilities, if they are functionally or structurally obsolete or inadequate in accordance with established directives. Consult the public works officer, or directives in the 11.000 series on military construction planning and project scheduling. NAVFAC P-80, on "Facility Planning Factors for Naval Shore Activities," especially the section covering dispensaries, may be helpful. Any project that costs over $50,000 must be referred to Congress as military construction, except in emergencies.

Again, the above figures are approximations, and depend to a large extent on local needs. They should not be considered as specific recommendations for any facility.

Medical Equipment

Specific equipment lists are not given because, to a large extent, the need will depend on local factors and the physician's preference.

- *Standard medical equipment.* Besides usual diagnostic instruments, including thermometers, the following should be provided:

  Patient transport equipment: wheeled litters and wheel chairs
  X-ray view boxes
  Beam scale
  Vital capacity apparatus (timed)
  Steam sterilizing facilities
  Facilities for suturing and other minor surgery
  Ear irrigation equipment
  Materials for application of casts
  Assortment of crutches for loan
  Special diagnostic instruments: audiometer, orthorater
  Tonometer

- *Emergency equipment*

  Inflatable splints
  Resuscitator with oxygen
  Pressor agents and blood expanders

- *Electrocardiograph machine.* ECG tracings should be mounted and placed, together with the interpretation, in the patient's file. Appropriate records are kept, similar to the procedure for keeping radiographs.

- *Physiotherapy equipment.* Several modes for physiotherapy treatment are desirable. These may include diathermy, ultrasonic and hydrotherapy apparatus. Such treatment is given only on the physician's order or, in the case of prescribed treatment recommended by a consultant, with the physician's knowledge and approval.

The nurse can usually be instructed to handle such treatments. A prescription form stating mode, intensity, area, duration, and frequency of treatment is helpful. (See "Sample Forms," page 79.)

Night Service

Inevitably, there will be some, and perhaps many, persons working on shifts other than the regular one. The total number working will determine the extent of services necessary at night. In many instances, "standby" personnel (nurse and physician) will suffice; special situations may require on-duty personnel or arrangements with a nearby medical facility. If services are to be provided on station, services of a X-ray technician must be available.

In all instances, however, special care is necessary to provide for proper and complete records and reports of all cases treated outside regular hours. This may be accomplished by providing a brief but precise routine for handling, recording, and referring such patients. A simple form which provides a record of circumstances, treatment and instructions has been developed for this use. (See "Sample Forms," page 79.)

Other Services

Laboratory Service

The clinical laboratory should be equipped to handle routine urinalysis and blood work, and special tests required for periodic evaluations for hazardous occupations.

Necessary equipment for routine cultures for sensitivity should be available. If it is necessary to send some special tests out to other laboratories, extra care should be given perishable specimens.

X-ray Service

A competent technician should be available to evaluate on-the-job injuries; otherwise, it will be necessary to refer many minor injuries.

Routine 14 X 17-inch chest films are preferred for pre-hire and periodic examinations. Films may be lent to private physicians and consultants, provided accurate records are kept of their whereabouts. Patients X-rayed should be listed in the X-ray

log with date, name, part X-rayed, and permanent film number recorded. The standard form for request and report of radiographic examination should be used.

A radiologist should be available for consultation. A duplicate of the report should be placed in the X-ray jacket with the film; the original is placed in the patient's medical jacket.

Industrial Hygiene

The service of industrial hygiene specialists concerned with such environmental factors as proper lighting, ventilation, noise levels, air-borne levels of toxic materials and the like should be available. Quite often by studying the work area, the hygienist cannot only detect the agent most likely causing the dermatitis, but also suggest ways for protection against continued exposure. In short, the industrial hygienist is capable of recognizing, evaluating, and recommending controls for hazardous environments.

Where such services are needed, the physician is advised to contact the Navy Industrial Environment Health Center (see page 10).

Records Maintenance

The Civil Service employee's medical record has been fairly well standardized. Only a few instructions for their handling will be given here.

Routine Instructions

- Keep these records in the Occupational Health Clinic and make their contents available only to authorized persons. Keep them in open-shelf files which are most efficient, particularly when there are many employees. However, make provisions for locking the files.
- Periodically, remove and forward inactive records through the proper channels for storage.
- Use standard forms where available. Each page should bear the proper identification of the patient.
- Keep record of immunizations, particularly for tetanus, readily available. Include this with the medical history, or make it part of the record of medical care if immunizations or periodic boosters are given.
- Place in patient's records additional information, if desired. Note on the jacket allergic reaction to medications, and the presence of certain conditions such as diabetes.
- Note conditions such as diabetes, physical limitations, etc., which require periodic review in pencil above the treatment record (inside the chart). In this

way, the review may be accomplished at the time of a dispensary visit for some other condition, and thus save the patient a return visit.

Handling of Medical Information

Technically, such medical records are in custody of the Civil Service Commission. Exercise great care to prevent unauthorized or unnecessary release of confidential information. In intra-agency reports of medical examinations, such as recommendations for physical limitations, it is not necessary to justify the limitation by revealing the diagnosis. Within the agency, where necessary, include an interpretive report prepared by the physician.

Because the Safety Department customarily handles compensation claims, an interchange of medical information often occurs. Take precautions to insure that personnel dealing with these matters are thoroughly indoctrinated with the concept of privileged information. In addition, the occupational health physician should abstract any reports received from other physicians which relate to the compensation aspects, and forward only that portion necessary for report purposes.

Confidential information may also be released inadvertently when an employee returns from sick leave. Sometimes, instead of, or in addition to, the *physician's statement* (on SF 71-109, Application for Leave, p. 101), the physician may give the patient a summary of the findings. In such instances, this report should be retained in the medical file. The necessary data may be entered on the leave form and signed *by* the occupational health physician *for* the attending physician to support the leave request.

In requesting reports and summaries from other agencies or private physicians, have the patient sign a release for such information. However, certain laws do permit free exchange of medical information between government agencies, including the Veterans Administration and the military services.

Exercise great care in providing medical reports about employees on the request of insurance companies, even with the employee's authorization. If the request is for evidence of good health, such *may* be complied with. If, however, any evidence exists that the information may relate to a possible compensation case, the request must be referred to the district office of the Bureau of Federal Employees' Compensation.

COOPERATION WITH OTHER RESOURCE GROUPS

Medical policies and medical procedures governing situations such as working conditions to be corrected etc., are set by the Occupational Health Clinic, which ranks

with top management. Various regulations which provide for this should be consulted as necessary, and the occupational health physician should be familiar with other available resources.

Command and Civilian Personnel

The occupational health physician should be familiar with the names of certain command and civilian personnel in most naval installations, and of special local officials such as the regional medical director of the Civil Service Commission, director of the Poison Control Center, etc. Their names, addresses, and phone numbers should be written down and placed in a readily available file (see Table 1). A close working relationship with these persons is mutually beneficial.

Safety Department

Because their areas of interest and responsibility merge, the Safety Department and the Occupational Health Clinic in an activity should cooperate fully and jointly to fulfill their missions. The Medical Officer should advise the Safety Officer of his observations of significant hazards. He may request the Safety Officer, or a member of his department, to accompany him on his routine inspections, particularly his special visits to work areas.

The occupational health program can contribute significantly to preparing and implementing the activity's Disaster Plan by providing some first aid instruction. It can also be responsible for orientation programs and special training to explain health services and treatment policies, and advise on particular health problems, when they appear. For example, supervisory employee training should include a presentation on prevention of back, and perhaps hand, injuries.

Civil Service Commission

The full-time physician is automatically a federal medical officer as well as the agency (activity) medical officer.

On problems concerning the Certificate of Medical Examination, the Civil Service Commission has regional branches with medical officers who will gladly advise on the problem (see Table 1).

For questions concerning treatment or referral of employees for occupational injury, the Office of Federal Employees' Compensation has district offices with both medical officers and rehabilitation counselors (see Table 1) available to offer their services.

Table 1 – Local Resource Information

LOCAL ACTIVITY	PHONE NO.
Director, Civilian Personnel	
Employee Services	
Safety Director	
Director of Administration	

REGIONAL CIVIL SERVICE COMMISSION

Regional Medical Officer: _____

Office Address: _____

Phone No. _____

DISTRICT BEC (BUREAU OF EMPLOYEES' COMPENSATION) OFFICE

Office Address: _____

Phone No. _____

POISON CONTROL CENTER

Address	Director	Phone No.

Navy Industrial Environmental Health Center

If problems concerning occupational medicine, industrial hygiene, and health aspects of air and water pollution are encountered, consultation is available from:

Navy Industrial Environmental Health Center
3333 Vine Street, Cincinnati, Ohio 45220
PHONE: Area Code 513, 684-3947 AUTOVON: 989-3947

Private Physicians

Having private physicians of the community cooperate in an ongoing occupational health program is an asset. This can be accomplished by the medical officer participating in the medical activities and meetings of the area, by personal contact, and by consultation regarding individual patients.

The occupational health physician should inform other physicians how his program functions. A list of physicians in the area should be available for referrals, as well as a list of specialists in surgery, ophthalmology, orthopedics, and dermatology. He should be able to enlist their cooperation in improving problem areas, and be responsive to their suggestions. It should be emphasized that a large part of the occupational health physician's contact with patients is to cultivate a "health awareness" in them—that they are referred to their own personal physician for definitive diagnosis and care when real problems persist.

Local, State and National Organizations

Useful information and, many times, services or educational materials are available from outside organizations. See "List of National Organizations Concerned with Occupational Health," p. 187.

Some organizations with particular interest in occupational health are the Public Health Service, most State health departments, and several of the larger insurance companies. Information on health, medical, or social services provided by local branches of these groups and other organizations in the community is usually available from the local Red Feather or United Givers office, or the Chamber of Commerce.

Various drug companies also make their educational materials available. Before any of these materials are requested in quantity, a sample should be carefully screened for pertinence and absence of promotional matter.

Most State health services operate laboratories which perform cultures, acid-fast stains and cultures, examinations for rabies, and other tests. County health services are also available in many localities.

PART TWO

CLINIC ROUTINE AND

STAFF RESPONSIBILITIES

PART TWO

CLINIC ROUTINE AND STAFF RESPONSIBILITIES

Reception and Records Clerk, 13
- General Requirements, 14
- Receptionist Desk Duties, 14
- Keeping a Daily Log, 15
- Pre-hire Examination Routine, 15
- Keeping Health Records, 15
- Preparing/Filing Compensation Forms, 18
- Disposition of Other Records and Reports, 19

Nursing Staff, 21
- Administrative/Supervisory Duties, 21
- General Nursing Duties, 21
- Health Evaluations, 23

Occupational Health Physician, 25
- Work Environment Orientation Duties, 26
- Emergency Care Duties, 27
- Physical Examinations, 29
- Placement of Women Who Work, 41
- Determination of Employee Fitness, 42
- Administering the Annual Health Program, 43
- Health Education and Counseling, 43

Supplementary Information for Physicians, 44
- Industrial Hygiene and Occupational Diseases, 44
- Role of the Industrial Hygienist in Occupational Environment Control, 45
- Sight Conservation Program, 46
- Hearing Conservation Program, 47
- Employment of the Handicapped, 48
- Workmen's Compensation, 49

Maintaining a record of clinic activity is essential to efficient operation of an occupational health program. The clinic routine and staff duties described here are concerned with the orderly processing of patients through the clinic for checkup and/or treatment and initiating the systematic generation of paperwork to record and follow up on the findings.

Within this framework, various staff members are assigned specific responsibilities. The types and number of personnel required have already been covered briefly in the foregoing chapter. However, duties of the three important members of the clinic—the reception and records clerk, the nurse (or chief nurse if there are more nurses than one), and the physician—will be described in greater detail here since they are more involved in the day-to-day operation of the occupational health clinic.

RECEPTION AND RECORDS CLERK

In most clinics, a separate reception and records clerk assumes responsibility for the receptionist and paperwork routine. However, in small clinics, the nurse may assume these duties.

General Requirements

The clerk selected should be courteous and friendly and be skilled in typing and filing. The clerk should also show tact and patience, as well as resourcefulness in handling emergencies. Besides possessing these requirements, the clerk should also be trustworthy—to have the capacity for preserving the confidential nature of medical information. The clerk must never release any information on the diagnosis or other findings to anyone (unless specifically authorized in each instance). No one, other than medical personnel, is allowed to remove or examine any medical records. This also means that such information is not to be subject for conversation outside the clinic.

Since the clerk is responsible for filing records and preparing reports, he must see that they are filed properly at the end of the day and not left exposed to public view. He must also be careful that a copy of all correspondence regarding a patient is placed in the patient's medical record.

Other Office Duties

- Ordering needed office supplies and forms.
- Scheduling, as directed by the nurse, all routine examinations, including pre-hire examinations.
- Answering the telephone.
- Preparing, in accordance with pertinent instructions, all correspondence, reports and forms.

Reception Desk Duties

- General routing. Direct dispensary visitors to the treatment, consultation or waiting room as indicated.
- Handling of emergencies. Stamp or write the date and time of arrival on slips of clinic visitors presenting NAVSO 5100/9 (in duplicate). Pull their civilian medical record from the file and attach the slip to the front with a paper clip. (NAVEXOS Form 107 has been redesignated NAVSO 5100/9, and the old designation is still used sometimes.) Bring the emergency situation to the attention of the nurse in charge, or see that the record catches up with the patient if he is already being examined elsewhere in the dispensary.
- Patient assistance. Take the chart or other forms from the patient after he has been treated. If there is a prescription, direct him to the pharmacy. If the patient is being sent home, arrange transportation as directed by the nurse, and notify the employee's supervisor of disposition. Prepare any additional reports or forms and give the patient his copy of the NAVSO 5100/9 and any

other form to return to his supervisor. Also help the patient secure transportation, if necessary.

- Preparing requests for test and filing sick leave records. According to the purpose of the patient's visit, prepare the appropriate requests for preliminary tests, laboratory studies, radiographs, audiometric or vision tests. For employees returning from sick leave, take the SF 71-109, Application for Leave, and/or statement from their physician, and place with form NAVSO 5100/9.

Keeping a Daily Log

Enter the name of each person visiting the Occupational Health Clinic in the daily log, which becomes the source for preparing reports, especially for those on NAVMED 6260/1.

The log is a ledger-type record that describes each entry with the following 12 headings: consecutive patient number for the quarter of the year, name, position, department, time in, time out, occupational (check if appropriate), non-occupational (check if appropriate), remarks, purpose of visit, diagnostic class, and employee status (Fig. 1). Use descriptive code numbers to explain the last three headings. Table 2 lists the keys to the descriptive code for the civilian employee record log. This descriptive code should be attached to the inside front cover where it may be easily located for reference while entries are being made. Another copy may be tacked on to wall bulletin board in the office for easy reference.

Pre-hire Examination Routine

Take the forms from applicants reporting, direct them to cloak rack, and then seat them in waiting area. Prepare requests for laboratory work and X-rays, then give their records to the nurse. Also see that applicant prepares Optional Form 58 or SF 93.

On completion of examination, type up any necessary letters, records, or release forms. Check that forms are signed and that applicable portions, including the medical officer's recommendations (on SF 78), are completed. Then direct the applicant to return to the Civilian Personnel Office with the second page of SF 78. In event that the applicant is not qualified, return the entire file to the Civilian Personnel Office, except file copies of letters of inquiry (see under "Correspondence" and "Medical Records of Applicants Not Employed," p. 19).

Keeping Health Records

Prepare a health record for each new employee entering government service. This record remains in the custody of the Occupational Health Clinic (Medical

Consecutive No.	Name	Position	Dept.	Time In	Time Out	Occupational	Non-Occupational	Remarks	Purpose of Visit	Diagnostic Class	Employee Status
01234	John Doe	Welder	Public Works	1130	1220				1	62	N
01235	Jane Doe	Clerk typist	Circuit Design	1400	1430				4	44	4B

Fig. 1 Sample page from civilian employee record log of patient visits.

Table 2 – Keys To Descriptive Code For Civilian Employee Record Log

KEYS TO PURPOSE OF VISIT
1. New occupational injury (injuries)
2. New occupational medical condition(s)
3. Occupational followup treatment (injuries and medical conditions)
4. Nonoccupational medical condition(s)
5. Nonoccupational injury (injuries)
6. Return for X-ray, laboratory test, etc., after a previous examination
7. Return from sick leave
8. Retirement and separation
9. Pre-hire examination
10. Periodic examination (renewal), complete examination
11. Evaluation
12. Nonoccupational cases referred or admitted (sent home)
13. Other

DIAGNOSTIC CLASS CODE NUMBER	
Eye problem(s) – 36	Physical therapy – 60
Allergy – 38	Podiatry – 61
Cardiology – 39	Emergency room – 62
Dermatology – 41	General practice – 63
Gastroenterology – 43	General medicine – 44
Neurology – 46	Return from sick leave – 00
General surgery – 52	Pre-hire examination–complete physicals – 01
Orthopedics – 54	Periodic checkups (BP's, etc.) – 02
Urology – 58	

EMPLOYEE STATUS
N – means that injured employee is not graded on the GS (general schedule) rating system
4B – means that the injured employee is graded on the GS rating system

Department) until his employment is terminated. Then remove it from the files and forward to the appropriate agency for storage.

Use a form DD-722 as jacket to hold the health record. Keep forms in jacket in the following order:

On right-hand side of the jacket:

SF 78–Certificate of Medical Examination

Optional Form 58 or SF 93–Report of Medical History (Use of SF 89 prohibited for civilian employees by the Civil Service Commission.)

SF 519–Radiographic Reports, to which SF 519a is attached

SF 545-557–Laboratory Reports

SF 601–Immunization Record

Other standard forms (audiometric record, orthorater card, correspondence and miscellaneous reports concerning the employee)

Duplicates of CA-1 & 2 and CA-16

On left-hand side of the jacket:

SF 600–Record of medical care

SF 513–Consultation sheet

Other standard forms

Make a notation at the top of each page, in red, regarding drug allergies or special conditions such as diabetes. (See BUMEDINST 6150.19 series.)

Preparing/Filing Compensation Forms*

Notice of Injury (CA-1 & 2). When appropriate, prepare Form CA-1 & 2, Employee's Notice of Injury or Occupational Disease, in triplicate after the patient is treated. Give the original of the NAVSO 5100/9 to the employee to take to his supervisor. Forward the duplicates of the CA-1 & 2 and the NAVSO 5100/9 to the Safety Officer, and file the third copy of the CA-1 & 2 in the employee's health record.

Supervisor's Report (CA-1 & 2). If the employee will be disabled for work beyond the day of injury, or is likely to suffer future or permanent disability, send two copies of CA-1 & 2 to the employee's supervisor or other person designated to complete this portion "Official Supervisor's Report of Injury." When filled out, send both copies to the Safety Department which refers the original to the appropriate Office of Federal Employees' Compensation.

Referral (CA-16). Fill out the necessary Form CA-16, Request for Examination and for Treatment, if the patient is referred to a federal medical officer or hospital, or private physician of his choice for treatment. Prepare the form in quadruplicate: the original to accompany the patient, the second and third

*It should be noted that no provisions are made under compensation law for replacement of personal property damaged or destroyed in an accident. This applies to clothing, eyeglasses, removable dentures and orthopedic appliances. However, such loss is provided for under the Civilian and Military Personal Property Act.

copies to go to the Safety Department, and the fourth to be filed with the patient's record. If it is impractical to send the form with the patient, send it within 48 hours. Note:

- ☐ Item 6a should be checked if condition is occupational.
- ☐ Item 6b should be checked if the occupational relationship is questionable.

- *Referral to Private Physician* (CA-16). If patient is referred to a private physician, also issue CA-16. The employee has the right to make initial selection of a qualified private physician if government facilities are not available or practical. Prepare form in quadruplicate and distribute as indicated for referral to a federal medical officer. (See foregoing paragraph.) This is used where government facilities are not available or when the services of a specialist are required.
- *Notice of Recurrence of Disability* (CA-2a). If the patient is seen for a recurring disability from a previous injury, and not more than 6 months have elapsed, the employee can be referred for further treatment. In this instance, prepare Form CA-2a. If more than 6 months have elapsed, request instructions from the district office of the Office of Federal Employees' Compensation. This last procedure is also necessary if a patient reports latent or delayed disability from an occurrence that happened more than 6 months ago, but not previously reported, or if he reports an occupational illness.

Disposition of Other Records and Reports

- *Monthly and quarterly reports.* Abstract data for such reports from the daily patient log, following instructions contained in *Manual of the Medical Department*, Chapter 23.
- *Medical followup cards.* Prepare and file such cards. Place in a suspense file for retrieval at the appropriate time. When the patient returns for followup visit, extract the card and attach it to the front of his record.
- *Correspondence.* Take care of necessary releases and requests for records. Place copy of such requests in the patient's medical record and another copy in a suspense file. Call to the physician's attention those requests unanswered after 10 days.
- *Medical records of applicants not employed.* File medical records of such cases separately but accessibly in an "inactive medical file." In such cases, pre-hire examinations may not have been completed (held pending receipt of medical reports), some applicants may not have been accepted, or some may fail to come to work after acceptance. Oftentimes, valuable and perhaps irreplaceable information has been incorporated into these records. For any

Table 3 – Handicap Code

NO.	CODE DESCRIPTION
00	No handicap of the type listed
10	Amputation of one major extremity
11	Amputation of two or more major extremities
14	Hernia
16	Hepatitis
20	Deformity or impaired function - upper extremity
21	Deformity or impaired function - lower extremity or back
25	Dermatitis
26	Allergy
30	Monocular vision
31	Substandard vision (no usable vision)
32	Substandard vision (contact lenses needed)
40	Hearing aid required
41	Severely impaired hearing (no usable hearing)
42	No usable hearing with speech malfunction
43	Normal hearing with speech malfunction
50	Tuberculosis, inactive, pulmonary
50-A	Tuberculosis (active or activity undetermined)
50-B	Emphysema or other respiratory condition
51	Organic heart disease, compensated
51-A	Organic heart disease, NOT compensated
51-B	Hypertension, NOT controlled
52	diabetes, controlled
52-A	Diabetes, NOT controlled (requiring insulin)
53	Epilepsy - adequately controlled
53-A	Epilepsy (other CNS symptoms), NOT controlled
54	Nervous, mental or behavioral problem requiring special placement effort
55	Mentally retarded
56	Mentally restored

applicant found *not qualified* (C or below), make a code entry under "Remarks" of the daily log to indicate the reason. This includes "X-report pending." The code is based on an expanded version of the physical handicap code (Table 3).

- *Repeat audiogram log.* Enter names of employees or pre-hire applicants determined to have defective hearing in a repeat audiogram log, together with the date of examination. Provide appropriate columns headed "Repeat at One Month," "Repeat at 6 Months," and "Final Disposition" for recording followup examination results.

- *Confidential medical reports.* From time to time confidential medical reports are received. The physician, after noting the contents, will mark these for file as "confidential." Place such reports in a manila envelope, and seal with cellophane tape. Write the name of the patient on the envelope, and make notation "To Be Opened by Medical Officer Only." Then place the envelope in the patient's record.

NURSING STAFF

The observation that an experienced and dependable nurse is the key to the well-functioning clinic underscores the important role of the nursing staff. Besides maintaining high ethical standards of the nursing profession, the nurse must also show patience and understanding in dealing with the public. The duties and responsibilities of the nurse in the Occupational Health Clinic generally fall under three broad categories: administrative/supervisory duties, general nursing duties, and health evaluations.

Administrative/Supervisory Duties

The nurse, or chief nurse if there is more than one, is the supervisor of all clinic personnel and is responsible also for most administrative duties. This includes:

- *Supervising clinic personnel* in general–including the receptionist/desk clerk
- *Scheduling examinations and preliminary tests* (laboratory and X-ray work)
- *Supervising the filing of medical records* and related reports, and making sure the confidential nature of the medical records is preserved, and unauthorized release of any medical information is guarded against
- *Supervising the completion* (by clerk-receptionist) *and proper routing of all forms* and other paperwork needed to process patient through the clinic.

General Nursing Duties

These duties which involve the patients when they come in contact with the nurse at this stage of their processing generally consist of preparing patients for examination, following up on their treatment and scheduling their return visits when necessary. The importance of recording in the beginning what happened, preferably in the patient's own words, cannot be overemphasized, whether injuries, illness, or return from sick leave is involved.

Preparing Patients for Examination by Physician

- *Record vital signs and other indicators.* Though readings on the blood pressure, pulse, temperature and respiration are not directly related to that particular visit, they may reveal previously unnoticed conditions such as hypertension. In any event, they provide base-line levels for evaluating future changes.
  - ☐ The temperature reading is particularly important in retreatment of injuries, since an elevation may indicate an early infection.
  - ☐ Patient's weight is another valuable indicator. Always record the weight of diabetics and cardiac patients.
- Cleanse wound and prepare lacerations for suture if necessary.

Post-examination Followup

- Check the doctor's orders and follow instructions. See that he has made entries in the patient's chart, completed NAVSO 5100/9 and ordered medication, if necessary.
- Make a record of patients requiring followup examinations. Schedule a return date. If patient fails to return as requested, advise the medical officer.
- Arrange referrals if requested. Be familiar with the procedures and the forms required for referring employees to private physicians. (See "Preparing/Filing Compensation Forms," pp. 18-19.) Schedule appointment with the private physician's office, call the Safety Office to arrange transportation, and notify the employee. Be sure to forward the necessary forms and X-rays or medical reports which should accompany the patient.

Keep a list of all referral physicians in the area—indicating those who are specialists and showing their specialties, their office address, office, home and emergency telephone numbers. In referrals to private physicians, send along with patient an in-house form letter explaining the availability of limited duty if the patient is unable to resume regular work. (See "Sample Forms," p. 79.)

Continuing Self Education and Health Promotion

- Expand skills to bett contribute to the occupational health program. Inspect work areas regularly see the working environment. (All nurses should be permitted/and encouraged to do so.) Learn the rules and the use and care of protective devices from the Safety Officer.

- Promote continuing good health care by:
  - ☐ Educating employees on good health practices such as sensible dieting, good personal hygiene, proper safety measures during a clinic visit.
  - ☐ Conducting or arranging for more formal sessions to meet specific needs, such as classes on proper diet and exercise for obese employees to lose weight.
  - ☐ Being well-informed of community services available. Know where to refer a shut-in invalid or a crippled child for assistance. Such information is usually available from the local United Givers Fund.

    For example, a program set up in cooperation with Alcoholics Anonymous should be available to provide advice and assistance to employees known to have a problem with alcohol. However, another program which stresses prevention by educating management personnel and supervisors in the causes and effects of excessive drinking and encouraging them to seek assistance, has greater potential.
  - ☐ Selecting monthly health topics and posting and distributing appropriate materials.

Health Evaluations

Pre-hire Examinations

Check pre-hire examination procedures and supplementary tests to be included in the physical with the Medical Officer. Though not required by the Civil Service Commission, audiograms and visual testing on the Orthorater are done at most naval installations. If supplementary tests are recommended, make sure the results of these procedures are available to the physician before he examines the applicant. The following procedures are usually recommended:

Urinalysis, including microscopic examination
Hematocrit (or hemoglobin) determination
Blood sugar determination (Dextrostix test)
Serological test for syphilis
PA chest X-ray, 14 X 17 inches
Tonometry on all applicants over 35 years of age

- *Processing Procedure*

1. Check the SF 78 for completeness of information to be filled in by the Personnel Office.

2. Scan the medical history form, Optional Form 58 or SF 93, for completeness and obtain additional information where pertinent.
3. Perform or supervise audiometric and visual testing.
4. Complete the portions of SF 78 which are appropriate.
5. Record height, weight, blood pressure, and pulse of examinees.
6. Prepare applicants for examination and remain in the room during examination of female applicants.
7. Bring to the physician's attention any abnormalities noted in the history or preliminary tests.

Periodic Health Evaluations

- *Examination of employees in hazardous occupations.* Make sure that persons required to have periodic evaluations will be scheduled, called in, and undergo preliminary observations. (See p. 79 for sample forms.) Schedule those requiring annual examinations, so far as possible, during their month of birth.
- *Medical followup.* Check file cards kept for workers requiring periodic health reevaluations. Such cards contain, besides the personal data, the diagnosis, employee occupation or position, date of visit, and a column for physician notation of return visit. Record such preliminary observations as blood pressure, weight and interim medical history. Forms used for diabetics and cardiacs are shown on pages 114 and 115.

  For the pregnant woman, have an initial hematocrit determination and urinalysis done; and a followup urinalysis thereafter, whenever the blood pressure has increased, or symptoms such as dependent edema are present. Note also, on initial visit, the attending physician's name and address, gestational history of patient, expected date of confinement, and use of medications.
- *Checking in employees upon return from sick leave.* Make sure that Civil Service employees check in at the Occupational Health Clinic when they have been absent from work for a certain number of days because of illness. Federal regulations require this after 7 days, but for Navy industrial-type activities, the Navy Industrial Environmental Health Center recommends clinic check-in after an absence of 3 days. This check-in serves the following purposes:

  ☐ To determine the individual's ability to return to work

  ☐ To determine his ability to return to the same job

- ☐ To make a medical note of the illness, particularly in the case of the onset of a chronic, although mild, condition
- ☐ To determine the job-related nature of the illness.

Note details of the illness briefly—including length of hospitalization and date of surgery (if any), the physician's name, as well as any medication still being taken by the patient. Be aware of any restrictions on activity recommended by the physician.

Remember that employees becoming ill at work are required to clear through the Occupational Health Clinic before leaving. (This does not apply to persons having medical or dental appointments.) This procedure is required to make sure that the employee's illness is not job-related. Any employee who does not follow this procedure must come through the dispensary when he returns to work, even if he was off less than 3 days, and he wishes sick leave credit for his absence. It is also desirable for persons who are sent home ill to report to the clinic dispensary upon return to work, for reasons already noted.

Form letters developed to secure additional information in certain circumstances are useful. Forms for employees returning after a "heart attack," and those where the private physician recommends indefinite limitations of activity may be found under "Sample Forms," pages 95 and 122.

Note: Check to see that the Physician Approval of Standing Orders (p. 52) is current.

THE OCCUPATIONAL HEALTH PHYSICIAN

The occupational health physician, whether Navy or civilian, is responsible for the overall function of the Occupational Health Clinic. His professional standards will set the tone for staff conduct and reflect the quality of the total employee health service. They will not violate the employee relationship to his personal physician.

The occupational health program he directs applies public health principles and sound medical, nursing, and engineering practice to care for the health of workers at their place of employment. Besides responsibility for the health aspects of the immediate environment, the occupational health physician is also concerned with less direct factors such as water supply, sewerage disposal, food sanitation, etc.

In meeting these responsibilities, he may find it necessary to share and delegate certain functions. The nurse and clinic staff should be thoroughly familiar with the standing orders for handling injuries and illnesses, approved and signed by the physician (see "Standing Orders," p. 52). Since the physician is also concerned with broader problems of environmental health, he is responsible for liaison with other

departments (e.g., the Public Works Department) and agencies, and he will need to work closely with other officials to assure cooperation and coordination.

The importance of professional liability cannot be overemphasized. Physicians are advised to provide for their own personal malpractice insurance coverage. (No public funds are available for this purpose, although in some circumstances, legal advice may be provided by the Department of Justice.) In occupational health practice the physician may be exposed to the increased hazard of personal liability. Such liability covers treatment and care of federal civilian employees entitled to benefits provided by the Federal Employees' Compensation Act, and may cover also, the care of military personnel and their dependents.

Clinic routine and specific responsibilities that the occupational health physician should be aware of will be covered briefly in the following sections.

Work Environment Orientation Duties

The physician should not only be familiar with the physical layout of the station, but be personally aware and knowledgeable of the various activities and processes involved. Only thus can he begin to appreciate and understand the conditions which may have resulted in injury or toxic exposure. Though no rules are set on the amount of time that a physician should spend on plant visitation, he is strongly urged to spend at least 10 percent of his time (about 4 hours per week) in the industrial plant and related areas.

An excellent opportunity for such observation is the periodic "line check-out" where manufacturing processes are reviewed. The Safety Officer can notify him of these. Check the following:

- Make an index of hazardous materials and processes, their locations, precautions to take, and/or methods of control.
- List, for toxic materials involved, the maximum allowable concentrations, symptoms of excess exposure, and means of treatment. Usually, the Safety Department will have most of this information. If an industrial hygienist is available locally, he can supply additional information.
- Keep a recent edition of a standard toxicology text on hand. Most materials in Navy industrial use are thoroughly covered in the *Industrial Environmental Health Bulletins* (NAVMED P-5112) and supplements published by the Bureau of Medicine and Surgery. Additional information may be obtained from the Navy Industrial Environmental Health Center or the nearest poison control center (see Table 1, p. 10).

Emergency Care Duties

One of the duties of the occupational health physician is providing for the immediate care and the disposition of all occupation-related conditions. He also has the opportunity to care for many other conditions.

It is Navy policy that care be provided for non-occupational conditions under the following circumstances: (1) if it is possible to keep the patient on the job until he can see her personal physician; or (2) when treatment would not ordinarily be sought.

Treatment of Occupational Conditions

Treat those occupational injuries and conditions that can be treated with the necessary facilities available. Consider also, the best interests of the patient. For example, it is preferable to refer a patient living some distance away to a private physician closer to his home, if he has sustained an incapacitating injury which requires daily dressings.

The aim is always to get the patient back on the job as soon as possible. Sometimes he can be returned to light duty immediately after treatment. But, if there is some condition which requires the patient to rest, do not be influenced by the supervisor, patient, or anyone else to keep the worker on the job.

Handling Compensation Cases

Use good medical judgement in handling situations where the injured worker may be entitled to receive workmen's compensation. Remember that the physician's duty is concerned primarily with restoring function. Though it is important to protect the government against unjust claims, it is equally important to protect the worker, and compensation is justified in many instances. It is up to the Office of Federal Employees' Compensation to determine whether a claim is approved or disallowed.

In many cases, e.g., finger injuries, some permanent disability may be inevitable. Recognize this and help the patient secure a settlement. It is best to refer the patient to an orthopedist who will rate his disability. Then direct him to the proper official to have his claim handled.

Humanitarian Treatment

Treat visitors, concessionaire employees, contractors working on government property and others who sustain injury or illness while on government premises. Give first aid, then refer them to private facilities if further treatment is necessary. Record such "humanitarian treatment" on an appropriate form (see "Sample Forms," p. 79), giving accurate details of the incident, findings, and treatment.

Differentiating Between Occupational and Non-occupational Injuries

Note that determination of which injuries are job-related and which are not is not too difficult since the injuries are apparent right away. For example, the following are occupational:

- ☐ Any accident to an employee occurring on government property, such as closing the car door on a finger when departing from or arriving at work
- ☐ Certain off-base accidents which occur in the course of official business or while the employee is on TAD.

For other circumstances under which injuries may or may not be occupational, check NCPI 5100. If there is any question at all, consider the accident "questionable." For example, to determine when a hernia or back injury may or may not be classified as occupational, consult NCPI 5100 for details. Generally, the alleged injury must follow a specific event. While some of these injuries may be considered occupational without such criteria, it is best to consider them initially as "questionable."

Note that determination of illness, such as headache and dermatitis as occupation-caused may be more difficult. However, always entertain the possibility. If there is any doubt, label as "questionable" on NAVSO-5100/9.

Check under duties of the receptionist/desk clerk (p. 18) for use of the CA-16 form, and for procedure initiating consultations or referrals.

Recording Clinical Data

As the Medical Officer is responsible for all entries in the health record, make sure that each entry is clear and concise, with sufficient details to establish the following:

Purpose of the visit

Diagnosis

Occupational or non-occupational involvement

Disposition or treatment

Instructions for further care and return.

All entries must be legible and signed. Record all vital signs. If limited duty is ordered, note the nature of the limitation (e.g., no lifting) and the duration. Note also any telephone reports or discussions about the patient.

Reporting Occupational Condition

In cases of occupational illness, such as dermatitis, summarize details on a special form to facilitate further investigation. If the services of an industrial hygienist are

available, forward the report to him as a notification and request for environmental evaluation. Sometimes, a Safety Department official may complete the evaluation. In many cases, the return report will indicate steps taken or controls recommended to correct an unhealthy situation (see under "Sample Forms" for local form Occupational Injury or Illness Report, p. 119).

Consultation with the Safety Department

When a series of accidents similar in nature occur, advise the Safety Department. Though reports are required, either send a memorandum or make a personal call to the Safety Officer for action. Oftentimes the physician is in a better position to note the similar nature of several accidents, whereas others may not, or may only recognize a hazard after an accident has taken place. Obviously close liaison and cooperation with the Safety Department and hygienist are highly desirable.

"On-the-job" First Aid

Make sure that plant personnel know that all injuries, however minor, must be referred to the Occupational Health Clinic as required by established policy. As transportation is readily available, by ambulance if necessary, it is not necessary or desirable for elaborate first aid kits to be kept at various locations in the station. Sterile gauze dressings may be provided for use on the job for extensive injury or hemorrhage. Discourage other measures.

Care of Military Dependents and Retirees

When employees being treated are also dependents of military personnel, give any required non-occupational treatment in accordance with the provisions noted under "Emergency Care Duties," page 27. Should the condition require more extensive investigation or treatment, have the individual make an appointment at the military clinic. Time off work for these employees keeping such appointments may be counted as sick leave. In other words, the Occupational Health Clinic considers such employees on the same basis as any other, and the military clinic is their source of care, for which time off work is not allowable unless charged to the appropriate category of leave.

Physical Examinations

As a representative of the government, the physician is expected to protect its interest. As a physician, he is bound to act in the best interest of the patient. The physical examination he performs on the applicant serves both.

Examination of Applicants for Light Duty Work

Note that certain exceptions have been made, as stated in *FPM Letter* 339-10, to routing procedures needed for applicants to obtain a certificate of medical examination before appointment to positions in the federal civil service. This involves use of SF 177, Statement of Physical Ability for Light Duty Work. Note that "new employees who have not received pre-appointment medical examinations may, at an appropriate time, be given medical examinations for occupational health program purposes."

Perform such examinations routinely on all new appointees at the earliest possible time. Use the same forms, tests, procedures, and considerations applicable in other pre-employment examinations. In addition, use either SF 93 or Optional Form 58 (see pages 99 and 111) to obtain a complete health history, without which any examination is incomplete.

Pre-hire Examinations

Although the pre-hire examination is supposed to fit the prospective employee to a position for which he is physically and emotionally qualified, the question in actual practice deals primarily with the capability of this particular individual to perform the duties of this position without hazard to himself or others. In view of this question, the emphasis should be placed on ability rather than disability.

At times, a decision on an individual's qualifications for the position is difficult. If necessary, obtain medical reports from private physicians, hospitals, or the Veterans Administration before fully evaluating the case. In certain instances, the individual's employment history may contribute materially to establishing his fitness. For example, some minor defect in an applicant for heavy labor would be of less consequence if he had worked for years in a similar occupation. However, such a defect might raise doubts if his previous work had been sedentary.

The Civil Service Commission requires that the decision is based on the individual's present condition. This involves good medical judgment. Whether the person has had a heart attack or even cancer is not necessarily disqualifying, nor is the possibility that he *may* become disabled at some indefinite time in the future. Thus, persons with a history of multiple sclerosis, Hodgkin's disease or chronic leukemia, may be qualified for suitable positions if the disease is in remission. *FPM Supplement* 339-31, which should be studied carefully by the medical officer and retained for reference, discusses these considerations.

Routine Preliminary Tests and Repeats

Certain preliminary tests and laboratory studies are done of the applicant in connection with his physical examination. They include routine urinalysis and blood

studies, blood pressure readings, vision and hearing tests, in which abnormal findings may suggest further followup study to rule out conditions such as diabetes, heart disease, etc.

As a rule, it is desirable to follow up on the abnormal findings listed below and repeat the tests.

- *For abnormal urinalysis.* Obtain a mid-stream specimen and repeat the urinalysis. If the abnormality is still present, advise the applicant to consult a private physician and obtain an evaluation and report.
- *For anemia.* Handle similarly after a repeat hematocrit or hemoglobin determination is still found to be low.
- *For elevated blood pressure.* Repeat the reading during the physical examination. If it is still elevated, repeat again after the patient has rested in a reclining position for 5 minutes. Should there be a persistent elevation of a significant degree, advise the patient to consult a private physician for treatment, and return when his blood pressure has been controlled. (Such individuals should, upon employment, be recalled periodically to be re-evaluated for adequacy of control. Note that there is considerable evidence that even transitory elevation of blood pressure in an otherwise healthy individual may presage the onset of significant hypertensive disease.)
- *For inadequate vision.* Process applicants reporting for examination without adequate visual acuity to assure absence of other disqualifying factors. Advise them to return with suitable glasses. If they present with contact lenses, and are applying for a position which is exposed to eye hazards (e.g., operating motor vehicles, feeding machines and/or working with explosives), advise them similarly (see also "Sight Conservation Program," p. 46). Use particular care in accepting persons with monocular vision.
- *For defective hearing.** Consider any audiogram showing a hearing level in excess of 25 dB (ISO-1964 hearing level standards) at any frequency through 3000 Hz to be outside normal limits. In such cases, repeat the audiogram on a manual audiometer, making certain that testing conditions are proper. If the same hearing levels are shown by the repeat audiogram, determine the cause, seeking otological consultation as needed. Do not expose to noise in excess of 90 dBA, those persons with a permanent hearing loss in the frequencies of

*_The Manual of the Medical Department_ (MANMED 15-27-App II) defines the speech frequencies as 500, 1000 and 2000 hertz (Hz) per second and indicates that the "better ear" is determined by averaging three readings taken per ear in these frequencies. ISO (International Standardization Organization) standards are used.

BUMEDINST 6260.6B requires that each person, civilian or military, assigned to duty involving exposure to noise greater than 90 dBA shall have a reference audiogram on file. Clearly labeled as such, it is recorded on a SF 600 and kept permanently in the individual's health record.

500, 1000 and 2000 Hz and a greater than an average of 40 dB in the better ear.

For persons without such loss, take a "monitoring" audiogram after they have been working for 3 months in a noise-hazardous area, unless an earlier test was necessary because of hearing difficulties. Obtain such an audiogram at least 40 hours after the last exposure to noise in excess of 90 dBA, to record permanent threshold shift. Obtain additional monitoring audiograms if difference between the monitoring and reference audiograms is:

Less than 10 dB at or below the 2000-Hz frequency, or
Less than 15 dB at or above the 3000-Hz frequency.

If permanent loss is greater than the above, take appropriate action to prevent further loss. If the next monitoring audiogram taken 3 months later indicates further permanent threshold shift, reassign the person to an area of less hazardous noise.

Check further details of the hearing conservation program as set forth in BUMEDINST 6260.6 series. (See also "Hearing Conservation Program, page 47.)

- *For cardiac conditions.* Evaluate any cardiac or circulatory condition carefully. If possible, obtain standard 12-lead electrocardiograms in applicants with any of the following abnormalities:

  A history of heart disease or coronary occlusion
  A history suggestive of angina pectoris
  Hypertension of marked degree
  Murmurs and arrhythmias

  For any individual found to have a cardiac condition, complete the diagnosis as recommended by the American Heart Association, with reference to: (1) etiology, (2) anatomy, (3) physiology, (4) function, and (5) therapy.

- *For diabetes.* For applicants with confirmed diabetes, first obtain a history of treatment and record on CSC Form 3684, Report of Diabetes Mellitus. Those applicants whose diabetes is controlled by diet and/or oral medication may qualify for most positions. But those applicants who require insulin and whose diabetes is less well controlled should refrain from performing the following tasks:

  Operating motor vehicles or machines
  Working above ground level
  Engaging in other hazardous work

  At any rate, refer applicants whose urinalysis or blood sugar suggest the possibility of diabetes to his personal physician for further evaluation. For such cases, it is good practice to request two specimens (of blood or urine)—a

2-hour post-prandial, and a fasting specimen. Such persons may be employed if under treatment. However, recheck them periodically to insure continued care.

Examination Report Procedure

Use the following forms to report physical examination findings:

SF 78–Certificate of Medical Examination

SF 93 or Optional Form 58–Report of Medical History

Check all items to see if any require further elaboration. Also, check audiogram, vision report, laboratory reports, and chest films, if available. Pay special attention to the following details:

- On report of medical history forms (SF 93, or Optional Form 58)

  Weight gain or loss
  History of back trouble
  History of neurological disturbances or fainting
  History and length of military service, if applicable
  Draft classification status
  History of dermatitis, allergy or asthma
  Date of last menstrual period in females
  Blood pressure (on SF 78)
  Anemia (on laboratory report)
  Elevated blood sugar and/or glucosuria (on laboratory report)
  Microscopic findings, e.g., abnormal urine sediments, etc. (on laboratory report)

  Elicit full details about any history of compensation or disability. Unfortunately, some persons are not completely honest and attempt to conceal facts which they feel may preclude their employment, despite the fact that such employment might be unsuitable and further endanger their health.

  Check for important but otherwise undisclosed information, if appropriate. First, any male who served in the Armed Forces for less than a year should explain why. Second, an inquiry about draft classification may reveal that some physical impairment made applicant unacceptable for military service (but does not necessarily, depending on the position, make him unacceptable for employment).

- Under Part B, SF 78–Functional Requirements and Environmental Factors

  Correlate the above findings with the duties of the position. In particular, restrict severe hypertensives and diabetics on insulin from certain activities.

Remember that emotional stability is important in some positions; the absence of dermatitis and allergy is important in others. Preclude heavy lifting and carrying in those with a history of back trouble, particularly in those having had disc operations. (It may be advisable in certain instances to obtain lumbar spine films for future comparison. Recognize, however, that such films, even routine ones, are of little value in predicting future difficulties.) It is advisable also to inquire about any previous history of back disorders. In positive cases, examine the back for range of motion, abnormal curvature or flattening, and record reflexes and results of straight-leg raising.

- Notes for completing Part C (the examination section), of SF 78
  - ☐ Under 4a (eyes, ears, nose and throat), note condition of the teeth, e.g., the presence of caries, or absence of teeth which may stimulate corrective action.
  - ☐ Under 4d (skin and lymph nodes), note any distinctive scars or tattoos which might aid in identification.
  - ☐ List other conditions not specified on form, such as dependent edema, a missing digit, spinal or chest deformity, or scar of previous injury.

    As a rule, more time should be spent in evaluating an older person than in a younger individual, such as one recently discharged from the Armed Forces.
  - ☐ Under "Conclusions," summarize findings after considering all factors, and indicate the physical category of the individual.

    Class A: Physically fit for any position

    Class B: Physically fit for the above position, with minor or remediable defects

    Class C: Physically fit for modified work in above position

    Class D: Physically unqualified for above position

    Class E: Physically unqualified for any position

    Class X: Temporarily unqualified pending further information or treatment

    If the applicant requires corrective glasses to meet the visual standard, include qualifying statement "when wearing glasses," i.e., "Class B, when wearing glasses."

- Notes for completing Parts D and F of SF 78

  Note any disqualifying factor and enter the handicap code. Complete other requested information. (*Note:* Since no space is provided for it under page 2

of "Certificate of Medical Examination," it is recommended that the physical handicap code be recorded also under "Conclusions" for future reference.)

At this time, record also any condition requiring followup, such as mild hypertension or a diabetic condition, so that a medical followup card is prepared and the return date noted. Finally, order a tetanus booster or the beginning of a series, if needed.

Special Problems

- *History of nervous or mental disorder.* Applicants with history of nervous or mental disorder may be acceptable for many positions, but not those which requires carrying a weapon. Nor are such persons recommended for highly sensitive positions. Obtain a report from the hospital or attending physician to aid in the determination.
- *Epilepsy.* Persons with a history of epilepsy controlled (seizure-free without medication) for a period of 5 years may be qualified for non-hazardous positions.
- *Tuberculosis.* If patient has a history of tuberculosis active within the previous year, request a summary from the attending physician describing the treatment given, the response, present status and suggested followup.

  If the tuberculosis was active between one and three years previously, give a CSC Form 4434, Medical Report–Pulmonary Tuberculosis to the attending physician to fill out. Take standard chest films every three months for one year, then annually.

  If the tuberculous activity occurred more than three years ago, use the same form (CSC Form 4434), and order annual followup 14 by 17-inch chest films to be taken.

Post-Physical Recommendations

The Occupational Health Clinic acts in an advisory capacity only. The occupational health physician's findings do not constitute an acceptance or a rejection of an individual for employment–that is a management decision. Clearly, if it is likely that the person will be employed, it is to his advantage and to that of the government that any information developed during his consideration which would affect his future health and employment be utilized.

- *For classes A, B, and C.* After the physical examination, give applicant a report of tests given him, any abnormal findings, and pertinent recommendations. Also explain the role of the Occupational Health Clinic, the services available and how to obtain medical care. This information may be given in a

small explanatory brochure or included in the orientation commonly given to new employees. Make provisions to inform new employees that they should report any significant change in their health status to the Occupational Health Clinic, particularly the development of heart disease, hypertension or diabetes, the beginning of contact-lenses use (see "Sight Conservation Program," p. 46) or the onset of pregnancy.

- *For classes C, D, and E.* (A class C designation due to limitations on activity or a class D or E designation due to physical disqualifications which make it unlikely that the applicant will be accepted for a position is only a medical recommendation.) After the examination, return applicant to the Civilian Personnel Department for final action. The Civilian Personnel Department is responsible for informing the applicant of the decision. If a reason is given, the applicant will be told that he does not meet the usual medical standards for the position. He will not be returned to the Occupational Health Clinic for an elaboration or justification of the findings. His right of appeal should be explained to him.

Periodic Health Evaluations

As noted previously, certain groups of employees are called in periodically for checkups, as warranted by their condition. Primarily, these are employees with diabetes, hypertension and cardiac conditions. The purpose of such an evaluation is two-fold: (1) to ascertain the individual's continued fitness to continue his duties, and (2) more importantly, to evaluate his condition in terms of adequate medical care. Other conditions which may need periodic followup include pregnancy, emphysema and physical handicaps.

Generally, the physician should not attempt to treat or to modify the treatment the patient is receiving, but verify instead that the patient is under regular medical care and the treatment is adequate. Use a simple form for summarizing these periodic visits. See pages 114 and 115 for sample diabetic and cardiac followup sheets.

- *Evaluation of employees in hazardous occupations.* Periodically, call in workers exposed to unusual stress or hazard to have their health evaluated. In the case of drivers and machinery operators, check primarily for continued good health and the absence of conditions which might lead to loss of balance or consciousness. Where toxic materials are present, detect deleterious effects in an early reversible stage. See Table 4 (pp. 38-39).
- *Health maintenance.* Make annual evaluations part of a health maintenance program. Note that minor changes from year to year, such as weight increase, increased blood pressure, etc., can constitute the focus of a health

improvement program. Plan a preventive educational program around personal habits and safe driving. Report basic findings to the employee's personal physician for action and followup. For additional information, consult *How to Practice Prospective Medicine.**

- *Annual or "executive" physicals.* Provide periodic health evaluations for certain other groups of employees, who are "key" personnel. Such a procedure is common in industry, though participation most often is on a voluntary basis. Provide a full report of examination to the individual's personal physician. Content of such examinations may vary considerably and depends to some extent on the time and facilities available. *Periodic Health Evaluations* (Public Health Service Publication No. 1010) presents much useful information.

Fitness-for-Duty Examinations

It is the duty of the Medical Officer, upon request, to perform such examinations and determine whether or not a medical problem exists. To be effective as a medical advisor to management, make sure the requesting department provides the following information:

- ☐ Physical requirements and position description
- ☐ Description of the duties which the employee has not performed in a satisfactory manner and the reasons for suspecting that ill health is the underlying factor
- ☐ Statement that the employee has been appraised of the situation and has consented to the examination.

When the employee reports to the clinic, ask him whether, during the previous year he has received any medical care or treatment. If he has, secure a summary of such treatment from the appropriate source. If a mental and emotional evaluation is warranted, arrange a referral to a psychiatrist. When this evaluation is received, proceed with any part of the physical examination as necessary to determine the presence of any medical disability which would contribute to employee inability to perform his job satisfactorily.

Report results and findings of the examination to the requesting official in a statement which notes whether the patient continues to be (or is not) qualified to perform his duties. (See "Administrative Problems of Physically Unqualified Employees," page 50.

*L. C. Robbins and Jack H. Hall, *How to Practice Prospective Medicine*, Indianapolis: Methodist Hospital, 1970.

Table 4–Hazardous Occupations and Health Evaluation Procedures and Spacing of Examination Intervals

HAZARD CODE	OCCUPATION	CHIEF HAZARD OR CONSIDERATION	Audiogram	Blood Sugar 2 Hr. p.p.	Chest X-ray 14" × 17"	EKG	Eye Examination (Vision)	Hematocrit (Hemoglobin)	History & Physical Exam	Icteric Index/ SGOT*	Porphyrins*	Urinalysis	Vital Capacity	WBC & Differential Count	Other Special Procedures
	A. EQUIPMENT OPERATORS & CLIMBERS														
01	Automotive equipment operators	Hazardous and/or arduous duty; visual changes, medical conditions which may result in sudden unconsciousness	a	Y	Y	a	Y	Y	Y			Y	Y		BC
02	Chauffeurs		a	Y	Y	a	Y	Y	Y			Y	Y		BC
03	Crane operators		a	Y	Y	a	Y	Y	Y			Y	Y		BC
04	Engineers, hoisting and portable		a	Y	Y	a	Y	Y	Y			Y	Y		BC
05	Firefighters		a	Y	Y	a	Y	Y	Y			Y	Y		BC
06	Guards		a	Y	Y	a	Y	Y	Y			Y	Y		BC
10	Locomotive engineers		a	Y	Y	a	Y	Y	Y			Y	Y		BC
07	Materials and equipment handlers		a	Y	Y	a	Y	Y	Y			Y	Y		BC
08	Scaffold workers		a	Y	Y	a	Y	Y	Y			Y	Y		BC
09	Truck drivers, including explosive drivers		a	Y	Y	a	Y	Y	Y			Y	Y		BC
	B. LEAD WORKERS	Anemia, liver & brain damage													
15	Battery workers	Also cadmium, mercury, acids			Y		Y	Y	Y	b	b	b	Y		BC
16	Cable splicers	Lead			Y		Y	Y	Y	b	b	b	Y		BC
17	Cutters/welders of lead-painted or coated material	Lead			Y		Y	Y	Y	b	b	b	Y		BC
	Lead azide workers	Lead			Y		Y	Y	Y	b	b	b	Y		BC
18	Lead burning and melting workers	Lead			Y		Y	Y	Y	b	b	b	Y		BC
20	Linotype operators	Lead			Y		Y	Y	Y	b	b	b	Y		BC
21	Non-ferrous foundry workers	Lead, manganese			Y		Y	Y	Y	b	b	b	Y		BC,NE
22	Remelt men	Lead			Y		Y	Y	Y	b	b	b	Y		BC
	Riggers	Lead			Y		Y	Y	Y	b	b	b	Y		BC
23	Solderers	Lead			Y		Y	Y	Y	b	b	b	Y		BC
24	Spray painters	Lead, solvents			Y		Y	Y	Y	b	b	b	Y		BC
25	Welders	Lead, metal fumes			Y		Y	Y	Y	b	b	b	Y		BC
	C. EXPLOSIVES WORKERS (handling the following)														
30	Amatol	Amatol		Y	Y		Y	Y	Y			Y	Y		BC
31	Composition "B"	RDX, TNT		Y	Y		Y	b	Y	Y		b	Y		BC
32	Composition "C," Cyclonite, RDX, CH6	Hexamethylene tetranitramine		Y	Y		Y	Y	Y			Y	Y	Y	BC
33	Explosive "D"	Ammonium picrate		Y	Y		Y	Y	Y			Y	Y		BC
34	Hg fulminate, mercurous nitrite	Hg (metal & CNS damage)		Y	Y		Y	b	Y		Y	b	Y		BC,NE,SK
35	Pyro compounds & mixtures	Various dyes & explosives		Y	Y		Y	Y	Y			Y	Y		BC,SK,WT
	RDX (See Composition "C")														
36	Tetryl	Dermatitis, conjunctivitis		Y	Y		Y	Y	Y	b		Y	Y		BC,SK
37	Torpex			Y	Y		Y	Y	Y			Y	Y		BC
38	TNT, Trinonal	Anemia & liver damage		Y	Y		Y	b	Y			Y	Y		BC
39	Missile fuels & oxidizers, including Otto fuel	Fuels & oxidizers		Y	Y		Y	Y	Y			Y	Y		BC

	D. WORKERS EXPOSED TO OTHER CHEMICALS														
44	Asphalt workers	Pitches, tars			Y		Y	Y	Y			Y	Y	Y	BC,SK
45	Benzol workers	Benzene			Y		Y	Y	Y			Y	Y	Y	BC
93	Chemists	Various chemicals			Y		Y	Y	Y	Y		Y	Y	Y	BC
	Chlorinated hydrocarbon handlers	Chlorinated hydrocarbons			Y			Y	Y	Y		Y	Y		BC(UT)
46	Degreasers	Aromatics, trichloroethylene			Y			Y	Y	Y		Y	Y	Y	BC(UT)
47	Electroplaters, metal coaters	Acids, CD, CN, nitrates, Sb, Zn			Y			Y	Y			Y	Y		BC,NA
48	Epoxy resin workers	Curing agents, etc.			Y			Y	Y			Y	Y		BC,SK
49	Heat treaters (metal)	Cyanides, fumes, etc			Y			Y	Y			Y	Y		BC
95	Lab workers	Various chemicals			Y		Y	Y	Y	Y		Y	Y	Y	BC
50	Paint steppers	Solvents, lead			Y			Y	Y	Y	Y	Y	Y	Y	BC
51	Pest controllers	Pesticides			Y			4	Y	Y		4	Y	Y	BC,CH,NI
52	Polyurethane foam workers	Phenol vapors, TDI			Y		Y	Y	Y			Y	Y		BC,SK
	Trichloroethylene handlers	Trichloroethylene			Y			Y	Y	Y		Y	Y		BC,UT
(44)	Handlers of waxes, pitch and tar	Aromatics			Y		Y	Y	Y			Y	Y	Y	BC,SK
	F. WORKERS EXPOSED TO RADIATION														
68	Laser workers	Non-ionizing radiation													RI
67	Radar operators	Microwave radiation													RI
66	Radium/radioactive material handlers	Ionizing radiation													RA,RI
65	X-ray technicians	X-rays													RA,RI
	I. WORKERS EXPOSED TO RESPIRATORY HAZARDS														
	Asbestos/insulation workers	Asbestos			Y			Y	Y			Y	Y		BC,AW
75	Buffers & polishers	Silica, dusts			Y			Y	Y			Y	Y		BC
76	Foundry workers	Silica, dusts, fumes			Y			Y	Y			Y	Y		BC
77	Grit blasters	Silica, dusts, noise	a		Y			Y	Y			Y	Y		BC
78	Magnaflux operators	Dust, ultraviolet light			Y			Y	Y			Y	Y		BC,SK
79	Pipe coverers	Asbestos			Y			Y	Y			Y	Y		BC,AW
80	Sand blasters	Silica, anthracite, dust, noise	a		Y			Y	Y			Y	Y		BC
	G. OTHERS														
90	Aviation technical observers	Flight													AV
91	Cold-room workers	Cold			Y			Y	Y			Y	Y		BC
94	Industrial hygienists	Any hazard	a	Y	Y	~	Y	Y	Y	Y	Y	Y	Y	Y	BC
92	Noise hazard area workers	Noise	a		Y			Y	Y			Y	Y		BC
	Scuba & "hard hat" divers	Pressure changes													DI

DESCRIPTIVE CODE

* or equivalent test
a – in accordance with BUMEDINST 6260.6 series
ao – at age 35, then every 2 years, or more often, if indicated
AV – examine in accordance with MANMED 15-69
AW – comply with NAVSHIPSNOTE 5100.26 series
BC – blood chemistries of SMA-12 or "Profile" as indicated
CH – cholinesterase determination every 14 days
DI – examine in accordance with MANMED 15-30
NA – special attention to nose on annual physical
NI – neurological examination
RA – examine in accordance with NAVMED P-5055
RI – examine in accordance with BUMEDINST 6260.10 series
SK – special attention to skin on annual physical
UT – urinary trichloroacetic acid (for trichloroethylene)
WT – special attention to weight on annual physical
4 – every 4 months
6 – every 6 months
Y – yearly (This is interval unless noted otherwise.)

Disability Retirement Examinations

To be eligible for retirement, an employee must have compiled at least 5 years of federal employment, and his disability must not have been due to intemperance, vicious habits, or willful misconduct. *Intemperance*, as used here has been held to mean alcoholism; *vicious habits*, to mean drug addiction; and *willful misconduct*, to mean venereal disease.

Disability, according to the Civil Service Commission, is defined as being "totally disabled for useful and efficient service in his [employee's] position or in any other position of the same grade or class." This is not the same as total disability. A typist who somehow sustained the loss of several fingers might well be totally disabled for that position, but she could be reassigned in an appropriate position, in a setup advantageous to the government.

The Commission generally takes the stand that the differential diagnosis of chronic brain syndrome, Korsakoff's psychosis, alcoholic paranoia, etc., is so difficult that cause and effect cannot be determined. In such cases, adjudicate the claim not on the probable etiology, but on the degree of disability. Use similar reasoning to cases involving cirrhosis of the liver, and also to late manifestations of syphilis, which is always assumed to have existed for over 5 years.

The following conditions may be disqualifying employee for certain duties:

- ☐ Knee injuries resulting in meniscectomy, or ligamentous tears, especially in older persons
- ☐ Hip prosthesis–cup or replacement prosthesis
- ☐ Arterial graft or prosthesis
- ☐ Emphysema or pulmonary insufficiency (these patients may also have an associated ulcer)
- ☐ Use of certain medications, such as anticoagulants or "tranquilizers"
- ☐ Cardiac conditions: Stokes-Adams syndrome, cor pulmonale, angina, chronic fibrillation, A-V block.

Evaluate each condition on the basis of severity, considering the position and the duties involved.

Persons applying for disability retirement must present a report from their personal physician, preferably on SF 2801-B, together with the pertinent supporting evidence which must include a detailed history and the clinical findings. Place such information in a sealed envelope and mark it "Disability Retirement–Privileged–Private."

Remember that under most circumstances, no person may be retired for disability until he has been examined by a federal medical officer. As the federal

officer, you may examine the reports prepared by the private physician, but remember to replace them in a sealed envelope after reading them. Evaluate the information supplied and determine the accuracy of the findings. Ascertain that all necessary laboratory and X-ray reports supporting the findings are available. After taking a complete history of the condition in question, examine the patient.

List all the information required on SF 2801-B, including the date of onset of total disability especially, and a statement as to whether the condition was independent of vicious habits, intemperance or willful misconduct. If further information is needed, see *FPM Supplement* 831-1.

Other Special Examinations

Various circumstances may warrant other examinations. For example, personnel may be required occasionally to serve on temporary additional duty (TAD) away from their home stations for varying lengths of time. Specifically, *special fitness examinations* should be given personnel in the following categories well before departure date:

Personnel aboard submarines

Personnel assigned overseas for over a month

Another required special examination is the *sobriety* examination. Use it to determine whether the employee is fit for duty (not whether he is intoxicated). Recognize the legal implications of diagnosing intoxication and securing laboratory tests to determine the presence of alcohol, as alcoholism is definitely a problem.

Placement of Women Who Work

In most jobs, women can perform as efficiently and as safely as men. Because the average woman is shorter and lighter than the average man, and most equipment and machinery are designed for men, special working conditions for women require special attention. Although there is marked variation in the strength of individual women, size is not necessarily an index of a woman's strength (nor a male's for that matter). Furthermore, there is no practical test for measuring strength or stamina. The best guide to placement may be her previous work experience. Perhaps in doubtful cases, give her a trial period. However, the following factors should be considered in an industrial working environment.

Lifting Limits

Recommended limits for weight lifting as suggested by several professional groups have been the subject of local legislation. However, no absolute limit is set for either sex. Most position descriptions include required lifting limits.

Pregnancy

Continuing work by women who become pregnant presents several questions. No definite regulations pertaining to federal employees exist although guidelines such as the following are observed by most agencies and stations:

- Encourage (if not require) such women to report their pregnancies to the Occupational Health Clinic. The responsibility of the clinic personnel is to ascertain that she is receiving regular prenatal care, and the pregnancy is progressing normally, and not adversely affected by her work. A form letter advising the attending physician of his responsibility has been developed. (See Sample Forms, "Letter to Physician for Confirmation of Pregnancy and Advisability of Continuing Work," p. 118.)
- Recommend that pregnant women work only on the regular shift, and not more than 40 hours per week. Note that the length of time the pregnant woman may continue at work, and whether it should be modified, depends on
  - ☐ The nature of the work performed, as some women need to be restricted in the amount of standing, lifting, and stretching they do.
  - ☐ The absence of symptoms, complications or physical impairment.
  - ☐ The nature of the working environment–whether toxic exposure exists, particularly to agents such as aniline, benzol, toluol, lead, chlorinated hydrocarbons, mercury and turpentine, which may cause anemia.
- If adjustment of working conditions is advisable, consult the patient's attending physician.
- See the patient in the clinic at least once a month and check her weight, blood pressure, and for symptoms such as nausea, vomiting, vertigo, weakness or edema. Some cases may need an initial hemoglobin determination and periodic urinalysis.
- Allow patient 14 weeks of maternity leave, 6 weeks to be taken before delivery, and 8 weeks after.

Other Problems

- Refer problems involving menstrual disorders to the personal physician for preventive treatment. Give symptomatic treatment to women with dysmenorrhea so they may be able to complete the work shift.
- Be on the lookout for home problems causing frequent absence from work, and for veiled symptoms require counseling and perhaps referral.

Determination of Employee Fitness

Frequently, the medical officer is responsible for resolving questions for which no firm medical guide applies. Striving to serve the best interest of the employee and the government at the same time is very difficult.

For most conditions encountered on pre-hire examinations, some precedents have been established as guides to determine fitness for employment, and also as a base for other guidelines. But, remember that the status of an already hired employee is quite different from that of an applicant.

Note that workers who were in excellent health 10 or 15 years ago are still subject to the same ills and infirmities as the general population. The question most often presented is whether, in his changed status after a heart attack, a mental breakdown, or serious trauma (occupational or non-occupational), the worker is qualified to continue to work efficiently and safely. Experience has shown, for instance, that over 50 percent of patients who sustain coronary occlusion are able to return to their previous jobs. However, if the position is classified hazardous, it should be one requiring *sustained* energy output, and not irregular exertion, such as that of a fireman. The *Federal Personnel Manual* (*FPM* 831-1) contains additional information and discusses many of these problems.

Administering the Annual Health Program

Some form of an annual health program is generally made available to all civilian employees. Usually included in this program is some form of immunization and some mass screening test.

Include immunizations against influenza, tetanus, smallpox and diphtheria, and tests such as chest X-rays, blood glucose determinations, tonometry, vision tests, and blood pressure checks. Carefully evaluate content of the program, based on its usefulness and cost, and the personnel available to operate it. Accomplish more by varying the program content each year, and arranging its details and promotion through the employee services officer.*

Health Education and Counseling

Whenever a patient is seen, an opportunity to provide health counseling presents itself. Oftentimes, some concern or personal problem related to the patient's current complaint is detected. Family problems, such as concern over a child's health, may be involved. In such a case–

*For additional information and suggestions see *An Administrative Guide for Federal Occupational Health Units*, Public Health Service Publication No. 1325-A, rev. 1969, pages 15-35.

- Provide whatever information or assurance possible, and if necessary, direct patient to the proper community agencies.
- Take the opportunity to reassure or advise the patient about his own health during interviews with employees returning from sick leave or during periodic health evaluations.
- Make appropriate health pamphlets available in the clinic waiting room. Display health posters and current items of interest on a bulletin board or in other areas. Follow a yearly month-by-month schedule featuring a different health topic each month. Run related health articles in the daily bulletin or other local periodicals.

SUPPLEMENTAL INFORMATION FOR PHYSICIANS

Industrial Hygiene and Occupational Diseases

According to one definition, industrial hygiene is "the science of the preservation of the health of workers through study and control of the occupational environment." Following are some hazards found in the occupational environment:

Air-borne dusts, vapors, fumes or mists
Harmful chemicals
Excessive noise
Infectious agents (such as the anthrax bacillus in woolsorter's disease)
Radiant energy, ionizing and non-ionizing radiation
Vibration
Abnormal air pressure, temperature and humidity

Such hazards may cause local or systemic effects of an acute, or cumulative and chronic nature.

Besides ordinary injuries such as lacerations and sprains, most occupational injuries are acute and result from contact with chemical agents. Often this is caused by spilling or splashing of such agents which cause local damage to skin or eyes. Occasionally dermatitis due to allergy or sensitivity to some agent is present.

More costly, however, in terms of disability, loss of time and overall expense, are the rare but serious cases of cumulative and chronic exposure to harmful substances, which may result in systemic effects. Some materials are also carcinogenic. Examples of some harmful substances are uranium which damages the kidney; carbon tetrachloride, the liver; benzene, the blood-forming organs; and silica, the lungs. Since the possible harmful effects of many agents are known, periodic evaluations of workers exposed to them can detect early evidence of specific harmful effects while they are in a reversible stage or make it possible to prevent further damage. Always

weigh carefully, the advisability of placing or continuing a worker with an established, although mild, impairment in a position which may aggravate his condition.

Role of the Industrial Hygienist in Occupational Environmental Control

The work of the industrial hygienist is presented here briefly so the medical officer may better appreciate the problems involved and more effectively use these services.

Surveys and Samplings

Surveys are conducted and samplings taken for the following purposes:

- ☐ To determine the atmospheric levels of the various contaminants
- ☐ To test the effectiveness of present control measures
- ☐ To recommend controls to better contain the contaminants
- ☐ To investigate complaints
- ☐ To conduct research.

A preliminary survey by an experienced person is usually the first step taken to evaluate the situation and locate the potential hazard. These cover not only the substance used, but the product and by-products, and the physical process employed as well. Control measures in use are also evaluated. When an area of potential hazard is noted, air samples are obtained in a manner to represent the worker's exposure accurately.

After these samples have been analyzed and the exposure duration is considered, the results are compared with the ACGIH (American Conference of Governmental Industrial Hygienists) table of threshold limit values (TLV). In case of noise, radiant energy and other factors, other appropriate measurements are made. Should a significant hazard be found, the industrial hygienist may recommend control measures.

Hazards Control

Hazards may be controlled by the following means:

- ☐ At source by local exhaust ventilation, wet collection methods, and good housekeeping
- ☐ Dilution with uncontaminated air
- ☐ Isolation or enclosure of the process
- ☐ Substitution of less toxic materials or processes

- ☐ Use of personal protective devices, such as goggles or face shields, protective clothing (gloves, aprons, coveralls, footwear), respirators, protective creams, etc.
- ☐ Good equipment maintenance, improved housekeeping, and education.

Sight Conservation Program

Though this program emphasizes prevention of eye injuries, it recognizes the following guidelines:

- ☐ To assure that employees have the visual acuity to meet the job requirements
- ☐ To provide protection against eye injuries
- ☐ To provide proper care of eye injuries
- ☐ To educate employees in eye health and safety.

Eye Care and Working in Hazard Areas

Borderline visual acuity of itself is not a disqualifying factor. Some persons with monocular vision of long standing may be acceptable for positions in which they have demonstrated proficiency and safety awareness by previous experience. Such persons should always wear safety eyewear.

Those industrial areas, occupations, and processes considered eye hazards are designated so by the Safety Department in the plant. Generally, grinding or blasting operations, and splashes are designated eye hazards. All personnel assigned such work shall be issued appropriate eye protection. Any person to be employed or transferred to an eye-hazard area or occupation will be provided the necessary corrective protective eyewear at Navy expense. Although procuring and fitting such eyewear is usually handled by the medical staff, refraction is done by the private physician. The request for such eyewear is handled by the employee's supervisor.

Contact Lens Use in the Work Area

Health records for those employees who wear contact lenses should indicate whether the lenses are worn regularly or intermittently, and whether regular spectacles are available if needed.

Employees are not permitted to wear contact lenses while working in eye-hazard areas, around explosives, in areas of high temperature or humidity, or where they may be exposed to infrared rays. They should never work wearing a mask or hood because of decreased corneal oxygen thus available. In general, plant employees

should be discouraged from wearing contact lenses unless their work is indoors and sedentary or clerical in nature. (See AMA Publication No. 250.)

The Industrial Eye Health and Safety Committee of the National Society for the Prevention of Blindness made the following policy statement on contact lenses on October 1, 1971:

> Because of the increased risk to the eyes, the National Society for the Prevention of Blindness strongly advises that the use of contact lenses of any type by industrial employees while at work should be prohibited, except in rare cases. The National Society recommends that any exceptions be verified in writing to the employer by the physician or optometrist who sanctions such use in a specific industrial environment. Contact lenses do not provide eye protection in the industrial sense: their use without eye and/or face protective devices of industrial quality, should not be permitted. To be of industrial quality, safety eyewear devices must meet or exceed all the requirements of the American National Standard Practice for Occupational and Eye and Face Protection, Z87.101968, or later revisions thereof, as published by the American National Standards Institute, Inc.

A person with post-cataract aphakia should not work in a hazardous area or do heavy lifting because of the risk of retinal detachment.

Hearing Conservation Program

Continued exposure to loud noise resulting in permanent impairment of hearing has long been recognized. Preventing such loss is the objective of the hearing conservation program. Some tools and techniques employed in the program are the audiometric examination, noise measurement and analysis, engineering control, and noise attenuation through use of protective devices.

The Audiometric Examination

The audiometric examination is a valuable diagnostic aid used to detect differences in hearing levels. It must be conducted by certified audiometry technicians using equipment calibrated periodically in accordance with current directives, as specified in BUMEDINST 6260.6 series. The audiometric test frequencies shall be 500, 1000, 2000, 3000, 4000 and 6000 Hz, or as specified in the same BUMED instruction. Generally, the following audiograms are made:

- *Routine audiogram of new employee.* If an applicant for employment is found to have a significant hearing loss, notify his former employer of this fact. For a definition of defective hearing and the procedures to be followed, see under "Medical Records of Applicants Not Employed," p. 19, and "Repeat Audiogram Log," p. 20.
- *Reference audiogram* of an employee whenever he is placed or transferred to a noise-hazard area or occupation. Clearly label and note on an SF 600 as a

"reference audiogram," and include this information in the individual's health record. Since this is the base line against which possible threshold shifts will be calculated in the future, obtain the audiogram under carefully controlled conditions, at least 40 hours after the last exposure to high-intensity noise.

- *Monitoring audiograms*, the first of which is taken after three months' work in the noise-hazard area, unless complaints of hearing difficulties indicate an earlier check.

  ☐ Repeat monitoring audiograms annually thereafter if there are no complaints of hearing difficulties, and the difference between the monitoring audiogram and the reference audiogram is

  Less than 10 dB at 2000 Hz and below, or
  Less than 15 dB at 3000 Hz and above.

  ☐ Repeat monitoring audiogram in another three months, if the difference between monitoring and reference audiograms is greater than that indicated above. Take appropriate action and have the employee wear ear plugs and ear muffs, or decrease the duration of noise exposure.

Noise Measurement and Engineering Control

A noise level of 90 dBA (decibels on the A scale) or higher is considered hazardous continuous noise. Repeated impulse or impact noise of 140 dB, such as that from small-arms firing, may result in hearing loss in some individuals. Generally, where it is difficult to understand the loud spoken voice at a distance of one foot, the sound level is at least 85 dB.

Noise Attenuation with Protective Devices

Properly fitted ear plugs or ear muffs provide attenuation of about 15 dB in the lower frequencies to about 35 dB in the higher range. Plugs and muffs together provide from 35 to 40 dB noise attenuation at most frequencies.

Individuals with established hearing loss due to factors other than noise exposure do not present any special problems or risk of added damage from noise exposure. However, they should be reexamined periodically.

Employment of the Handicapped

While the occupational health physician is not directly involved in hiring the handicapped, he can and should periodically call the management's attention to many positions that can be filled by the handicapped. The "equal opportunity employer" hires the mentally and physically handicapped as well as the able-bodied. For example, many employees otherwise retired on disability may qualify for other

positions despite their handicaps. In some places, blind employees have worked out very well, aided by reading assistants.

Successful employment of the mentally handicapped depends upon proper job placement, understanding of problems such workers face on the job, and their acceptance by management and fellow workers. The physician can exert a very wholesome influence in overcoming prejudice and in promoting understanding of mental illness. However, certain positions, including those of guard or handler or worker with explosives or other hazardous materials, may not be desirable for persons with a history of serious mental illness.

No satisfactory "rule of thumb" can be used for defining serious mental illness, as each case must be considered individually. In general, employment is doubtful for an applicant who has a history of mental illness occurring within the preceding three years, and receiving prolonged or repeated hospitalizations and shock therapy. Moreover, the continued necessity for psychotropic medications is cause for concern. The possibility that the employee would require security clearance adds another element to the picture. A communication channel with the Security Department should be available, as information available in the medical record is oftentimes not available from other sources.

Workmen's Compensation

Some aspects of workmen's compensation is presented here for orientation purposes. Historically, the first efforts which led to the various occupational and industrial health programs in effect today were the outgrowth of laws placing the responsibility for occupational injury and disease on the employer. Such matters for federal civil service employees are handled by the Office of Federal Employees' Compensation (OFEC).

For workers sustaining death or permanent disability (partial or total) "in the course of, and arising out of employment," certain benefits are provided over and above the payment of medical expenses.

Compensation for loss of wages is payable after a 3-day waiting period in leave without pay (LWOP) status. No waiting period is required when injury is permanent or when the period of disability and wage loss exceeds 21 days. Compensation generally is payable on the following scale:

- ☐ Two-thirds of the employee's weekly salary if he has no dependents, or
- ☐ Three-fourths of the employee's weekly salary if he has one or more dependents.

The law provides scheduled benefits and payments based upon the loss of earning capacity resulting from permanent effects of an injury.

- *Scheduled benefits* are awards for permanent functional impairment of certain members of the body (such as losing use of an eye, arm, hearing apparatus, etc.) or for serious disfigurement of the head, face or neck. Such payments start at the end of the healing period, or when the disability has been overcome as much as possible. The employee may work and draw his regular wages concurrently with receipt of the scheduled award.
- *Compensation for loss of wage-earning capacity due to an injury* may be payable if the employee is unable to resume his regular work duties because of injury-related disability, and he suffers a wage loss. This compensation is based on the difference between the employee's post-injury capacity to earn wages and the wages of the job he held when injured.
- *Compensation in cases of permanent or long-standing disability*, after scheduled benefits have been used up, will be reconsidered by the Office of Federal Employees' Compensation, and may pay two-thirds or three-fourths of the difference between pay scales, if the employee remains in a lower-paying position because of his disability.

All claims and processing are handled by the Safety Department, according to instructions given in OFEC regulations and *FPM* Chapter 810. An employee having accrued sick leave may, in case of disability from an occupational injury, elect to use all or part of his sick leave in lieu of compensation.

Administrative Problems of Physically Unqualified Employees

Occasionally an employee is found not qualified for his position by a fitness-for-duty examination. The result of an injury or the onset of a disease, or an adverse reaction (e.g., a convulsion) may uncover the condition.

As soon as this becomes known, the Medical Officer should advise the department under which the employee works and the Civilian Personnel Office, and suggest reassignment. In some instances, reassignment is not possible, and the only alternative is separation or, if the employee qualifies, disability retirement. Permanent employees have certain reassignment rights that temporary employees do not have. In any case, the medical officer should consult with and advise other management personnel about the limitations and help arrive at a solution. However, an attempt should be made to place the employee in a suitable position if he is still capable of satisfactory service.

Forms to Use for Reporting Medical History

Standard Form 93 was developed for recording the medical history of civilian employees and job applicants as part of a physical examination. Optional Form 58 may be used (pending development of a new form), but only as part of a medical examination. The Civil Service Commission definitely prohibits using SF 89 for reporting the medical history in civilian employees.

PART THREE

STANDING ORDERS

FOR NURSING STAFF

PART THREE

STANDING ORDERS FOR NURSING STAFF

General Emergency Procedures, 53
- Bleeding Control, 53
- Resuscitation, 53
- Shock Prevention and Treatment, 54
- Prevention of Wound Infection, 54
- Care of Unconscious Patient, 55

Tentative Standing Orders for Specific Conditions, 55
- Abrasions, 55
- Animal Bites, 56
- Arthropod (Insect) Stings and Bites, 56
- Snake Bites, 58
- Thermal Burns, 58
- Chemical Burns, 59
- Cardiac Emergencies, 60
- Dermatitis and Skin Problems, 61
- Dysmenorrhea and Other Gynecological Problems, 61
- Earache, 62
- Live Insect in Ear Canal, 62
- Other Ear Problems, 62
- General Procedures for Eye Injuries, 63
- Burns of the Eye, 63
- Contusions of the Eye, 65
- Eye Pain, 65
- Foreign Body in the Eye, 66
- Other Eye Injuries, 67
- Vision Problems, 68
- Headache and Fever, 68
- Heat Disorders and Emergencies, 68
- Lacerations, 70
- Musculoskeletal Injuries, 71
- Nosebleed, 73
- Respiratory Infection, 73
- Toothache, 74

General Procedures for Occupational and/or Non-Occupational Disorders, 74

General Procedures for Death and Serious Injury, 75

Convenience Treatments Authorized by Private Physician, 75

Immunizations, 76

Detection of Emotional Problems, 77

An important statement concerning the legal scope of industrial nursing practice as published by the AMA Council on Occupational Medicine states:

> The observation of symptoms and the making of a diagnosis imply the need for professional learning and mental acuteness. These functions are characteristics of the professional nature of nursing as well as medicine. The industrial nurse who observes the extent of illness or injury to an injured workman, and determines whether she should render emergency treatment or wait until the physician arrives has made a vital diagnosis comparable in importance to many of those which physicians are called on to make. However, except for first-aid treatment and the employment of such measures as will prevent aggravation in the patient's injury or illness, the determination of therapy is within the exclusive domain of medical practice and beyond the limits of nursing practice.

PHYSICIAN APPROVAL OF STANDING ORDERS

The following standing orders have been reviewed by me and approved for use by the nursing staff. These orders will be followed in the Occupational Health Clinic unless other orders are given by the appropriate physician in specific cases.

NAME OF PHYSICIAN SIGNATURE DATE

Fig. 2. Sample form for physician approval of standing orders.

At times the nurse may have to be responsible for evaluating a patient's condition, and if the physician is not immediately available, render necessary emergency treatment, and provide for disposition of the case. For this reason the standing orders included here should be reviewed by the physician, modified as he desires, and authenticated by his signature (Fig. 2).

General Emergency Procedures

The following procedures apply in all emergencies:

- Call a physician immediately if his services will be required.
- Control bleeding.
- Restore breathing.
- Prevent shock and infection.
- Do no more than is actually needed.

Bleeding Control

1. Expose the wound.
2. Remove or loosen surface foreign matter.
3. Apply pressure over sterile gauze.
4. Compress blood vessel against bone at "pressure point" if bleeding is not controlled by pressure over sterile gauze.
5. Use tourniquet as last resort, applying tourniquet tightly, proximal to the wound as close to the injury as possible.
6. Additional orders: _____
   _____
   _____
   _____

Resuscitation (maintaining or restoring breathing)

1. If breathing is inadequate, start ventilatory support by manual or mechanical means.
2. Provide clear airway by removing any foreign matter, positioning patient and airway tube if needed.
3. If breathing has ceased, provide ventilation by mechanical means (resuscitator, Ambu bag, etc.), or by mouth-to-mouth resuscitation if mechanical means are not immediately available.

4. Additional orders: _____
_____
_____
_____

Shock Prevention and Treatment

Some degree of shock is present with every injury of consequence, and may be present even with minor injuries. Shock may be characterized by weakness, pallor, a moist and cool skin, excessive perspiration, a weak and rapid pulse, low or falling blood pressure, nausea and vomiting. Observe the following procedure if shock is suspected:

1. Have patient lie on examining table for cleansing or manipulation of wounds.
2. Maintain body warmth without overheating.
3. Give oxygen and ventilatory support as needed to provide adequate respiratory volume and oxygen intake.
4. Record pulse, blood pressure and general appearance as soon as possible.
5. If shock is not improved by above measures, start intravenous infusion of Ringer's lactate or 5% dextrose in water.
6. Additional orders: _____
_____
_____
_____

Prevention of Wound Infection

- For severe or complicated wounds, cover with a sterile dressing and protect the wound for transportation to hospital.
- For less severe wounds, when repair at the dispensary is anticipated:
  1. Protect wound with sterile gauze while cleansing adjacent area with soap and water.
  2. Shave area surrounding wound.
  3. Discard protective dressing, clean and shave to wound edges, then wash with soap and water.
  4. If further treatment is indicated in the immediate future, cover with sterile gauze while awaiting physician.
  5. Close minor wounds, as specified by the physician, by butterfly closures.

6. Protect against tetanus. If patient has not been given a series of tetanus toxoid previously, give 0.5cc alum-precipitated tetanus toxoid, and schedule for the remaining two injections. (See "Immunizations," p. 76).
7. Additional orders: _____

_____

_____

(See also treatment for specific wounds such as bites, burns, etc.)

Care of the Unconscious Patient

1. Insure adequate airway and keep patient in a semi-prone position to avoid aspiration of vomitus.
2. Insert oral or nasal airway and use suction as needed.
3. Give ventilatory support and oxygen as needed.

Tentative Standing Orders for Specific Conditions

Standing orders should be in effect for handling specific conditions. Tentative standing orders offered here should be approved by the occupational health physician. If they do not represent his wishes, he should make the needed changes, or write his own. These tentative standing orders have no authority unless approved and signed by him.

Some blank space has been left for the physician to write in medication and dosages of his choice. Where specific medications and dosages appear, these too are suggestions, and should not be interpreted as an attempt to tell any physician how to practice medicine.* Immediate treatment for some of these most commonly encountered minor injuries is described below.

Abrasions

1. Cleanse with soap and water.
2. Shave as necessary.
3. Remove foreign matter.
4. If abrasions are extensive or embedded with foreign matter, refer to physician.
5. Cover with non-adherent type dressing, such as Telfa or sterile vaseline gauze.

*A further source of guidance is Chapter III, *Handbook of the Hospital Corps* (NAVMED P-5004). A more detailed set of standing orders is also available on request from the Navy Industrial Environmental Health Center, 3333 Vine Street, Cincinnati, Ohio 45220.

6. Additional orders: _____
_____
_____
_____

(See also "Prevention of Wound Infection," p. 54.)

Animal Bites

Since all bites and stings are wounds, take precautions to prevent infection. The greater the amount of tissue damage, the greater is the danger of tetanus. (See "Immunizations," p. 76).

In *all* instances of bite by a warm-blooded animal, tame or wild, rabies is a major consideration. A physician should determine whether or not antirabies treatment is advisable. When possible, do not destroy the biting animal, but confine it under observation of a veterinarian for at least 10 days. If the animal must be destroyed, keep the head intact and submit it to the State Health Department or appropriate laboratory for inspection.

1. Notify physician of all animal bites, no matter how minor. (This includes rat and mouse bites.)
2. Do not close any animal bite with sutures or tape closures. Leave closure, if done, to a physician.
3. Cleanse wound and cover if dressing is needed. (See "Prevention of Wound Infection," p. 54.)
4. Report bite in accordance with current directives and local policy as follows:
5. Additional orders: _____
_____
_____
_____
_____

Arthropod (Insect) Stings and Bites

The greatest immediate danger presented by the sting or bite of an arthropod is an anaphylactic reaction. Milder allergic reactions may occur. Or infection may follow. (See "Prevention of Wound Infection," p. 54.) Certain arthropods may present specific problems.

- General orders applicable to stings and bites
  1. If stingers are present, remove with forceps, but be careful to avoid squeezing more venom into the skin.

2. If possible, identify the arthropod which bit or stung the patient. If this cannot be done, find out where the patient was when bitten or stung.
3. Inquire as to the type and severity of previous reactions to bites or stings.
4. For allergic reactions, give 0.5 cc of 1:1000 aqueous adrenalin (epinephrine) solution subcutaneously and notify physician.
5. If pain and local swelling are the only complaints, and sufficient time has elapsed to make severe allergic reaction unlikely, give a mild analgesic and an antihistamine as follows:_____

_____

_____

- Treatment for Specific Bites
  1. *Black widow spider bites.* Hospitalization may be warranted, though the bite is not often serious in adults. The patient usually complains of abdominal cramps. Symptoms tend to be severe.
  2. *Brown spider bites.* This spider is recognized by the violin-shaped marking on its back. On the second or third day following the bite, a central necrotic area develops. This lesion, when it develops, makes it reasonably certain that the bite was caused by a brown spider, if the arthropod had not been previously identified.
  3. *Scorpion bites.* If pain (the usual problem) is present, inject a local anesthetic and apply ice packs. This usually suffices. Seriously poisonous scorpions are usually not found in the United States.
  4. *Tick bites.* Aside from the fact that ticks may transmit specific "arthropod-borne" diseases, they may present another problem. If a tick with head embedded in the skin is torn away, the head may remain buried in the skin and provide a focus for infection. To remove an embedded tick, wet a cigarette or other tobacco and squeeze a drop or two of "tobacco juice" on the tick. This should cause the tick to disengage its head from the skin and facilitate removal. An alternative method is to touch the tick with an object warm enough to cause it to disengage its head. Do not however, apply anything to the embedded tick which will kill it in situ, as this will leave the head embedded in the skin. Deal with removed ticks and their body juices as probably infectious material.
- Additional orders: _____

_____

_____

_____

_____

Snake Bites

The principal factors influencing survival from snake bite are the type and volume of venom injected and the length of time before polyvalent or specific antivenom is given. The size and age of the victim may also influence the outcome, as may the state of victim's health. If a snake bite is suspected, proceed as follows:

1. Place the patient at rest in a position of comfort.
2. Reassure the patient.
3. Apply ice pack to area of bite.
4. Try to establish the identity of of the biting snake. See identification information on local snakes, which may be located at: _____
   _____
5. Note specific antivenom available as follows:
   Polyvalent Crotalidae: _____
   Specific for _____
   Specific for _____
   Specific for _____
   Note: An intensely painful bite suggests presence of a hemotoxin, such as that from pit vipers. A numbness at the bite suggests presence of a neurotoxin, such as that from a coral snake or sea snake.
6. Administer antivenom as follows: _____
   _____
   _____
   _____
7. Take precautions against allergic reaction to antivenom: _____
   _____
   _____
   _____
8. Additional orders: _____
   _____
   _____
   _____

Thermal Burns

Burns are described by the extent (percentage of body surface) and depth (first, second or third degree) of their involvement. While it may be difficult to assess the depth of burns accurately, a rough estimate of the extent of burns may be made by

applying the "rule of nines." Burns involving more than 15 percent of body surface are considered serious, and should be given care beyond initial first aid.

- *First aid for major burns:*
  1. Treat for shock. (See "Shock Prevention and Treatment," p. 54.)
  2. Immerse part in cold water or apply ice pack promptly if area is not greater than _____ . Continue until exposure to air does not cause pain.
  3. Remove clothing except that adhering to the burned tissues.
  4. Maintain airway and ventilation.
  5. Cover with sterile burn dressings or sheets.
  6. Protect against tetanus. (See "Prevention of Wound Infection," p. 54.)
  7. Additional orders: _____
     _____
     _____
     _____

- *First aid for minor burns:*
  1. Immerse in cold water or apply ice pack promptly, and continue until exposure to air does not cause pain.
  2. Cleanse with soap and water.
  3. Apply dressing as follows: _____
     _____
     _____
  4. Protect against tetanus as needed. (See "Prevention of Wound Infection," p. 54.)
  5. Additional orders: _____
     _____
     _____
     _____
     _____

Chemical Burns (see also "Chemical Burns of the Eyes," p. 63)

- Identify material causing burn.
- Adopt special procedures for the following type burns:
  1. *Acid burns:* Wash immediately with large quantities of water. Neutralize with sodium bicarbonate or _____

2. *Alkali burns:* Wash immediately with large quantities of water. Neutralize with vinegar or _____
_____
3. *Phenol, cresol and tar burns:* Neutralize with mineral oil or ethyl alcohol.
4. *White phosphorus burns:*
   a. Immerse part in water, excluding contact with air, and remove particles. Small particles may be seen and removed in a darkened room, since particles glow in dark.
   b. Wash wounds with 1% solution of freshly prepared copper sulfate. (Old solutions tend to become concentrated and may be dangerous if absorbed.) If it is desirable to have copper sulfate solution immediately available at all times, make sure it is changed often enough to minimize this danger. It will be changed every _____ .
   c. Wash away excess copper sulfate solution with water promptly, to lessen danger of absorbing harmful amounts of copper sulfate. Coating action of the copper sulfate covers the phosphorus particles and excludes air.
5. *Other chemical burns:* Wash thoroughly with soap and water to remove the agent.
   a. Treat as similar thermal burns, after taking special measures (including those recommended by manufacturer, where applicable).
   b. Additional orders: _____
   _____
   _____

Cardiac Emergencies

Symptoms may vary from "mild indigestion" to unconsciousness simulating fainting or cerebrovascular accident (stroke). Usually, one or more of the following symptoms will be present: faintness, breathlessness, chest or arm pain of a "squeezing" character, weak and rapid or irregular pulse, cyanosis or pallor, and sweating, perhaps with cold extremities. If a cardiac emergency is suspected:

1. Notify physician at once.
2. Keep patient in a comfortable position, sitting or lying down. NO WALKING ALLOWED.
3. If severe pain is present, give medication for pain and note time of administration. Give _____
_____

4. Record vital signs. Get history and EKG if practical.
5. Administer oxygen.
6. If patient is lying down and experiencing increasing difficulty breathing, prop him up in a sitting position.
7. When patient is transferred to the hospital, send records on the following with him: vital signs including initial blood pressure reading, history summary, note of pain medication given (type, amount and time of administration), and EKG tracing (if taken).
8. Additional orders: _____
_____
_____
_____

Dermatitis and Skin Problems

Contact dermatitis is fairly common. It may result from occupational or non-occupational exposures. Treat as follows:

1. Obtain careful history of exposures, previous episodes, previous treatment, if any, or medicines taken.
2. Use no topical or other medication without physician's order.
3. Refer all dermatitis cases to physician.
4. Additional orders: _____
_____
_____
_____
_____

Dysmenorrhea and Other Gynecological Problems

1. Inquire of the employee the date of her last menstrual period, and whether it was normal. In event of severe cramping, excessive bleeding or a missed period, refer employee to physician.
2. If shock is present or anticipated, treat appropriately. (See "Shock Prevention and Treatment," p. 54.)
3. If menses have been normal and similar symptoms of dysmenorrhea usually occur, give _____ .
Suggest that employee's personal physician be consulted before her next period is due.
4. Refer all cases of alleged rape or of other medico-legal import to physician.

5. Additional orders: _____
_____
_____
_____

Earache

1. Obtain medical history and record vital signs.
2. If there is no history of trauma or activity associated with air pressure change (as occurs in diving or flying), no temperature elevation or hearing impairment, or noise in the ear, and pain is relatively mild, give two tablets of aspirin (1.6 gm or 10 grains) stat or _____
_____ ,
if there is sensitivity to aspirin or other contraindication.
3. If pain is not relieved within one hour, refer patient to physician.
4. If there is indication of infection, impacted cerumen or other foreign body in the external ear canal, refer patient to physician.
5. Do not use ear drops until the patient has been seen by physician.
6. Additional orders: _____
_____
_____
_____

Live Insect in Ear Canal

1. Instill water (at body temperature) into the ear canal. Usually this will immobilize the insect and float it out.
2. Refer patient to physician.
3. Additional orders: _____
_____
_____
_____
_____
_____

Other Ear Problems

Refer to the physician all employees who show hearing loss or altered hearing, balance disturbance, a sense of ear being "stopped up," presence of a foreign body, or possible barometric or other trauma and fever.

Additional orders: _____

_____

_____

_____

General Procedures for Eye Injuries

1. Except in chemical burns of the eye, where flushing of the eye takes precedence over all other considerations, obtain a history of the injury.
2. Test and record visual acuity with and without glasses (if only ability to distinguish between light and dark or to count fingers in severe injuries) *before* treatment is attempted.
3. Use strict aseptic technique in all eye procedures.
4. Keep eye treatment equipment sterile and separate from other treatment equipment.
5. Handle all eye solutions with care to prevent contamination, and keep solutions freshly prepared, or for period no longer than a month.
6. For this reason, date eye solutions other than those packaged and sealed sterile by the manufacturer. Keep such solutions in glass-stoppered bottles without eye droppers.

Chemical Burns of the Eye

Different types of chemicals can produce burns which vary greatly in appearance. Acid burns tend to cause immediate tissue coagulation which tends to slow penetration of acid into the deeper layers. The appearance is generally worse than that of an alkali burn. Alkali tends to cause softening of tissue, which promotes continuing deeper penetration until the last trace of alkali is removed. Though it appears to be a milder burn, the damage tends to be greater. Give first aid treatment for the different types of burns as follows:

- *Acid burn:* Irrigate eye copiously with large quantities of water, to flush away acid. Irrigation should continue 20 minutes by the clock. Apply patch and refer to physician. Additional orders: _____

  _____

  _____

- *Alkali burn:* Irrigate eye copiously with large quantities of water, to flush away alkali. Irrigation should continue at least 20 minutes by the clock. Apply patch and refer patient to physician. Additional orders: _____

  _____

  _____

- *White phosphorus burn:*.
  1. Flush with water, and keep area wet to exclude contact with air. Particles present will ignite if exposed to air.
  2. Instill 1% freshly prepared copper sulfate solution to involved areas and flush immediately with large amounts of water. (The coating of phosphorus particles by copper sulfate occurs almost instantaneously. Do not keep excess copper sulfate present for once coating has occurred, the copper sulfate itself might cause damage if permitted to remain in the eye.)
  3. Remove larger particles using a cotton-tipped swab moistened with copper sulfate solution or saline. Continue flushing with water during removal operation. Remember the coated particles will ignite if exposed to air, i.e., if coating is broken.
  4. Therefore, dispose of removed particles of phosphorus as follows: _____
  5. When phosphorus has been removed to the extent feasible, patch the eyes with sterile gauze soaked in water or sterile normal saline and refer patient to physician. Additional orders: _____
     _____
- *Other chemical burns of eyes:* _____
  _____

Infrared, Laser or Microwave Burns of Eye

Usually discrete, these burns tend not to cause any pain or discomfort. Proceed with treatment as follows:

1. Refer suspected infrared, laser or microwave burns of eyes to physician.
2. Additional orders: _____
   _____
   _____
   _____
   _____

Thermal Burns of the Eye

Such burns are usually caused by hot liquid, hot foreign bodies, or other hot materials. Give first aid treatment.

1. Instill local ophthalmic anesthetic as follows: _____
   _____
2. Apply ice compresses.

3. Refer patient to physician.
4. Additional orders: _____
_____
_____
_____

Ultraviolet Burns of the Eye (flash burn, sunburn)

These burns may result from exposure to welding electric arcs, ultraviolet lamps or sunlight, especially when reflected from a surface such as snow. Typically, symptoms of such burns wait at least 8 hours *after* exposure before appearing. To treat:

1. Apply local ophthalmic anesthetic as follows: _____
_____
2. Apply ice compresses.
3. Refer patient to physician.
4. Additional orders: _____
_____
_____
_____

Contusions of the Eye

These result from blunt injury to the eye or orbit. Treat as follows:

1. Obtain history of injury.
2. Look for laceration or foreign body (see "Foreign Body in the Eye," p. 66).
3. Apply cold compresses.
4. Refer to physician.
5. Additional orders: _____
_____
_____
_____

Eye Pain

1. Obtain history.
2. Check for evidence of inflammation, infection or foreign body. (See "Contusions of the Eye" just discussed.)

3. If cause is not apparent and easily correctable, refer patient to physician.
4. Additional orders: _____
_____
_____
_____

Foreign Body in the Eye (See also "Chemical Burns of the Eye," p. 63)

1. Do not attempt to remove a penetrating or protruding foreign body. Patch to protect the eye (patching *both* eyes) and follow procedures described under "Penetration, Perforation or Rupture of the Eye," page 67.
2. Obtain medical history. If practical, save object from which foreign body may have come.
3. Examine eye using a hand light or flashlight, and look *beneath* the upper and lower eyelids.
4. Remove foreign material from lids or around eye by cleansing gently with warm sterile water or saline.
5. Irrigate eye gently, directing the stream to one side of the foreign body.
6. If irrigation is not successful, try removing foreign body by rolling a cotton-tipped applicator gently over it, away from the center of the pupil. The applicator may be moistened with sterile water or saline.
7. If foreign body cannot be removed easily, patch eye and refer patient to physician.
8. If spasm of lids interferes with examination of the eye, apply a drop of local anesthetic, such as proparacaine hydrochloride. This will help relax the lid spasm so that an adequate examination may be performed. (Foreign bodies on the cornea present problems in removal unless the lid reflex is overcome by local anesthetic.)
9. Patch eye, if local anesthetic is used, until it is rechecked the following day.
10. To detect residual corneal abrasion, use fluorescein, which will stain the abraded area slightly green. Use only sterile, freshly prepared fluorescein, such as that obtained from individually wrapped fluorescein strips (such as Fluor-i-Strip®). An open bottle of fluorescein may support growth of bacteria which can cause permanent eye damage.
11. Additional orders: _____
_____
_____
_____

Herpes zoster ophthalmicus

Herpes zoster involving the ophthalmic division of the trigeminal nerve can result in corneal ulceration and residual scarring. There may be severe pain in the region of the orbit before the typical vesicles of herpes appear.

1. Refer any case where herpes zoster ophthalmicus is suspected to a physician.
2. Additional orders: _____
   _____
   _____
   _____

Inflammation of the Eye

Generally, reddening of the conjunctiva and pain are present in inflammations of the eye. Purulent material may be present. Treat as follows:

1. Refer cases of eye inflammation to the physician. This includes cases where foreign bodies have been present in the eye(s) for 24 hours or more.
2. Additional orders: _____
   _____
   _____
   _____

Laceration of Eyelids

1. Do not remove any material, even though it may appear to be debris or foreign matter.
2. Patch *both* eyes lightly and refer to the physician.
3. Additional orders: _____
   _____
   _____
   _____
   _____

Penetration, Perforation or Rupture of the Eye

Sudden loss or impairment of vision or a sudden rush of tears in association with trauma suggests perforation or rupture of the eye. If perforation or intraocular foreign body is suspected:

1. Patch *both* eyes, to prevent eye movement.
2. Refer to physician.

3. Transport patient as a litter case if he has to be moved.
4. Additional orders: _____

Vision Problems

1. Refer all cases involving loss, impairment, blurring or other abnormality of vision to the physician.
2. Additional orders: _____

Headache and Fever

1. Obtain medical history, with special attention to head injuries and other symptoms, medication (especially antipyretics) taken, etc.
2. Record temperature, pulse rate, and blood pressure.
3. Refer patient to physician, if there is history of head injury, or if other symptoms such as dizziness, nausea, vomiting, general malaise, fever (oral temperature over 100°F), or other acute symptoms are present.
4. Give one or two tablets of aspirin if headache is mild and temperature is less than 100°F. Or, instead of aspirin, give _____.
5. Warn patient that if symptoms persist or worsen, he should see a physician.
6. Additional orders: _____

Heat Disorders and Emergencies

BUMEDINST 6200.7 series presents additional information on heat disorders, as does NAVMED P-5052-5. Note that reporting of heat casualties, both civilian and military, on NAVMED Form 6500/1 is required.

- *Heat rash.* The chief importance of miliaria or "prickly heat" lies in the fact that it may mark a candidate for more severe heat problems. Treat as follows:
  1. Obtain history and record vital signs.
  2. Refer to physician.

3. Additional orders: _____

_____

_____

_____

- *Heat cramps.* Usually involving the arms and legs, heat cramps may also occur in muscles of the chest and/or abdomen. They are usually preceded by profuse perspiration associated with muscular exertion. Characteristically, the skin is wet and clammy. Temperature may be mildly elevated. Nausea and vomiting may occur. Treat as follows:

  1. Obtain medical history, including information on water and salt intake. Record vital signs.
  2. Have patient lie down with head slightly lowered in a cool, well ventilated area. Loosen clothing.
  3. If conscious and able to tolerate fluids by mouth, give patient 1 liter of 0.1% saline orally. (To make up 0.1% saline, mix 110 ml normal saline with 890 ml tap water, or dissolve 1½ salt tablets (600-mg tablets) in 1 liter of tap water.)
  4. If patient is not able to tolerate oral fluids, start I.V. of 500 cc normal saline or _____

     _____
  5. Refer patient to physician or transfer to hospital as appropriate.
  6. Additional orders: _____

     _____

     _____

- *Heat exhaustion* (heat prostration). The symptoms are those of circulatory impairment. Weakness, vertigo and headache may progress to collapse. Muscle cramps, like those described earlier, may be present. Patient's temperature is normal or slightly elevated. *The chief differentiation from heat stroke is the presence of moist or wet skin.*

  1. Place patient in reclining position in a cool environment. Loosen tight clothing.
  2. Obtain medical history, if possible, including information on heat exposure, work, salt and water intake.
  3. Check pulse, blood pressure and temperature frequently and record.
  4. Give 0.1% saline by mouth if patient is conscious and able to tolerate oral fluids. (See "Heat Rash" and "Heat Cramps," pp. 68-69.)
  5. Treat for shock if present. (See "Shock Prevention and Treatment," p. 54.)

6. Refer patient to physician or transfer to hospital as appropriate.
7. Additional orders: _____

_____

_____

_____

- *Heat stroke.* This disorder is characterized by high fever (heat pyrexia) and collapse. Characteristically, *despite the high temperature, the skin is dry.* Muscular twitchings, cramps or convulsions may occur. Shock may develop. Vigorous treatment is necessary. Treat as follows:

1. Lower body temperature as rapidly as possible, using any means available, but avoiding frostbite of skin. Use ice bath, water-alcohol sponging, or electric fan blowing along with massaging the limbs toward the body.
2. Check rectal temperature every 5 to 10 minutes, and taper off treatment when temperature nears 100°F rectally, to avoid hypothermia. As temperature elevation may recur, continue to check for 8 to 12 hours.
3. Treat shock. (See "Shock Prevention and Treatment," p. 54.)
4. Avoid other medications if possible.
5. Transfer patient to hospital as soon as this can be accomplished safely.
6. Additional orders: _____

_____

_____

_____

Lacerations

Irregular and relatively neatly incised wounds are considered here. Depending on the location and extent of injury, shock or associated injury to deeper tissues may be present. Treat as follows:

1. Control bleeding and shock as needed. (See "Bleeding Control," (p. 53) and "Shock Prevention and Treatment," p. 54.)
2. Obtain medical history and record vital signs.
3. Protect laceration against infection. (See "Prevention of Wound Infection," p. 54.)
4. Refer patient to physician and/or make arrangements for followup.
5. Additional orders: _____

_____

_____

_____

Musculoskeletal Injuries

- *Contusion.* An injury to soft tissue or underlying structures by blunt traumas, a contusion is a bruise which may include discoloration of immediate or delayed onset, in which the skin is not broken. (Combined abrasion-contusion is common.) Contusions about the eye, knee and elbow commonly result in marked swelling or discoloration and much after-pain. Be alert for possible development of a hematoma in a contused area. Hematoma may be caused by damage to major blood vessels or may be due to disorders of the clotting mechanism. To treat contusion:

  1. Apply cold compresses or soaks to the contused area every 10 to 15 minutes to minimize swelling.
  2. In the absence of suspicion of fracture or other complication, apply a supportive elastic bandage. Caution the patient to watch for signs of impaired circulation, such as blue, cold and painful digits, and to return to the dispensary or loosen the bandage if they appear.
  3. If there is question of related injury or complication, refer to physician.
  4. Arrange for appropriate follow-up.
  5. Additional orders: _____
     _____
     _____
     _____

- *Strain.* Strain is overuse of a muscle resulting in pain and disability. Do not confuse strain with cramping due to impaired circulation, which occurs in claudication or "shin splints." To treat strain:

  1. Put the part at rest.
  2. Check for evidence of impaired circulation.
  3. Obtain and record history and vital signs.
  4. Apply local heat.
  5. Give by mouth, a mild analgesic such as 2 tablets of aspirin stat, and q4h, p.r.n. for a total of 12 tablets or _____
     _____
  6. If there is evidence of impaired circulation or other abnormality such as fever, refer to physician.
  7. Additional orders: _____
     _____
     _____
     _____

- *Sprain.* Sprain is a joint injury caused by stretching or tearing of supporting structures. All sprains should be seen by a physician, who will determine additional treatment. To treat:
  1. Place the patient at rest. Obtain and record history and vital signs.
  2. Elevate sprained extremity and apply cold compresses if injury has occured within 24 hours.
  3. If lower extremity is injured, avoid weight bearing. Have patient use wheel chair or crutches.
  4. Assume a fracture is present until proved otherwise. Get X-rays of part if this can be done conveniently.
  5. Additional orders: _____

- *Fracture or dislocation.* A fracture is a break in a bone while a dislocation is disruption of a joint. Dislocations may have associated fractures. To treat:
  1. Place the part at rest. Obtain and record history and vital signs.
  2. Be prepared to treat for shock. (See "Shock Prevention and Treatment," p. 54.)
  3. Immobilize part by splinting or other appropriate means. Avoid moving extremity suspected of fracture or dislocation. Do not attempt reduction or manipulation. Do not attempt to elicit crepitus.
  4. Obtain X-rays if this can be done conveniently.
  5. If there is an associated wound (as in a compound fracture), deal with it accordingly (see "Prevention of Wound Infection," p. 54), but do not attempt vigorous cleaning of bone.
  6. Consult physician on further disposition of patient.
  7. For pain, inject meperidine 50 to 100 mg I.M. stat, depending on severity, or _____
  8. Additional orders: _____

Nosebleed or Nose Injury

Nosebleed may occur without injury or it may occur after injury. Spontaneous nosebleed may occur in hypertension or blood disorders. Observe the following precautions:

1. Place the patient at rest sitting or lying down. Elevate head. Loosen clothing around the neck.
2. Record history and vital signs.
3. Apply cold pack to base of neck and/or upper lip.
4. Reassure patient. Ask patient to remain quiet and avoid blowing nose or clearing throat. Instruct him to open his mouth if he has an urge to sneeze.
5. If nasal fracture or dislocation is suspected, refer patient promptly to physician so that manipulation, if needed, can be done before "setting" occurs.
6. Additional orders: _____
   _____
   _____
   _____

Respiratory Infection

For minor respiratory infections, such as the common cold, mild cough or sore throat, follow instructions given below. For more severe respiratory infections, such as bronchitis, pneumonia or streptococcal pharyngitis, refer patient to the physician.

1. Record history and vital signs.
2. For uncomplicated upper respiratory infection ("common cold"):
   _____
   _____
   _____
3. For uncomplicated cough following a respiratory infection: _____
   _____
   _____
4. For non-streptococcal sore throat, without complications, such as fever or general malaise: _____
   _____
   _____
5. Additional orders: _____
   _____
   _____

Toothache

1. Obtain history, take te. ıperature and pulse, and check for swelling.
2. If pain is mild to moderate, and there is no swelling or temperature elevation, give analgesic as follows: _____
3. If pain is severe or persistent, or swelling or temperature elevation is present, refer patient to dentist.
4. Additional orders: _____

Orders for other conditions: _____

General Procedures for Occupational and/or Non-occupational Disorders

Some medical conditions, such as the common cold, are clearly not occupational in the usual sense, while other conditions such as dermatitis, may or may not be. Determination is oftentimes difficult and may require the physician's opinion or decision by OFEC of workmen's compensation laws.

Many ailments listed in this section could be subject to such confusion. In which case, an occupational relationship may need to be determined for disposition of the case.

In general, an employee with a less severe illness may be given palliative or symptomatic treatment to enable him to remain on the job until such time as he can (if necessary) consult his personal physician.

However, an employee who is more ill, such as one whose usual work might suffer or prove hazardous if continued by him under the circumstances, should be sent home, or directly to his physician.

Transportation by government conveyance is authorized if no other transportation is available, or if the case is urgent. At times, a patient will need to be sent directly to a hospital of his choice. In such a case, contact his personal physician and ask him to make arrangements for the patient's admission. If the patient is unconscious or uncooperative, secure the consent of the nearest relative (usually husband or wife) for information as to disposition.

Otherwise, the responsibility for notifying the family of serious illness or injury lies with the Civilian Personnel Office, and it is the duty of the nurse to notify the appropriate official. At night, the O.O.D. (officer of the day) should also be notified to take appropriate action.

General Procedures for Death or Serious Injury

While the law generally requires that a physician must pronounce a person dead, the fact of death is often obvious, as in certain cases such as decapitation, general body dismemberment or decomposition, even before legal pronouncement is made. In cases where a person is obviously dead, or where remains believed to be human are found, notify the following persons: _____

_____

_____

_____

Any accident or health hazard which results in the death of one or more persons, or the hospitalization of five or more persons must be reported to the regional office of the Occupational Safety and Health Administration (OSHA) within 48 hours. The regional office, in turn, will report it to the Secretary of Labor. Generally, the initial report will be made by telephone or telegram. Use OSHA forms 100 and 101 as guides to forward this information. The OSHA Regional Office is located at (address and phone) _____

_____

_____

Convenience Treatments Authorized by Private Physician

To prevent time lost from work, treatment properly prescribed by private physicians may be given, subject to the following conditions:

1. Written authorization with definite instructions is provided.
2. No condition requiring continued medical observation or laboratory study will be treated under this arrangement.

3. Medication is furnished by the patient. No medication likely to produce adverse reactions will be used.
4. The occupational health medical officer has approved the treatment in advance.
5. Such treatments will not be continued longer than 3 months without reauthorization. Note details and dates of such treatments on the patient's chart, clearly identified as convenience treatments for a non-occupational condition. Examples:
   - ☐ Iron injections
   - ☐ Vitamin B12 injections
   - ☐ Allergen-desensitizing injections. Unless otherwise ordered, do not give such an injection if the medical officer is not present.
   - ☐ Insulin injections. These may be given on a short-term basis while the employee is learning how to self-administer such injections.
   - ☐ Physiotherapy, such as hydrotherapy and diathermy. Give such treatment only in connection with occupational injuries, or when recommended by a consultant.

   Note: No antibiotics should be given.

Immunizations

An opportunity to obtain or renew immunization against such infectious diseases as smallpox, tetanus, influenza and polio may be offered from time to time as part of the annual health program for employees to keep their immunizations up-to-date. New employees will be given boosters or a complete series of tetanus toxoid as indicated. Whenever possible, other persons visiting the Occupational Health Clinic will also have their tetanus immunizations checked.

The general policy is outlined as follows:

1. Persons who have never been immunized or cannot recall definitely having been immunized, shall receive a complete series of tetanus toxoid. (Persons who have served in the military all receive immunization against tetanus.)
2. All other persons should receive a booster every 10 years, and after any injury which might expose them to tetanus.
3. The complete series consists of three injections: an initial injection; a second injection 4 weeks later, but no later than 6 weeks after; the third injection 8 to 12 months after the second. Alum-precipitated toxoid is preferred.

Note: Most recent instructions recommend tetanus reimmunization every 6 years. If the employee has already been given a basic series of tetanus toxoid before, boosters need not be given for minor injuries. In major contaminated injuries, give booster if no booster has been given the past year (alum-precipitated toxoid recommended). If the employee has never been given a basic series before, consider using tetanus immune globulin (human) for passive immunization. Do not use tetanus antitoxin either alone, or combined with gas gangrene serum since it presents risk of allergic reaction.

Detection of Emotional Problems

Often the first indication of other problems bothering the patient is picked up by the occupational health nurse, who should be alert to their occurrence. She recognizes that many factors influence a person's health, and consequently his value as a worker. A headache or drawn-out recovery from a minor injury may be traceable to home problems or dislike for the supervisor. Some authorities maintain that "accident-proneness" occurs in a definite type of person with emotional problems.

She should be familiar with the health resources of the community, and be able to advise the patient where to seek specialized help.

PART FOUR

SAMPLE FORMS

SAMPLE FORMS

Bureau of Employment Compensation (BEC) Forms
- CA 1 & 2: Federal Employee's Notice of Injury or Occupational Disease, 84
- CA-2a: Notice of Recurrence of Disability, 88
- CA-16: Request for Examination and Treatment, 90

Standard Forms (SF)
- SF-78: Certificate of Medical Examination, 92
- SF-177: Statement of Physical Ability for Light Duty Work, 95
- SF-93: Report of Medical History, 99
- SF 71-109: Application for Leave, 101
- SF 2801-B: Physician's Statement in Connection with Disability Retirement, 102

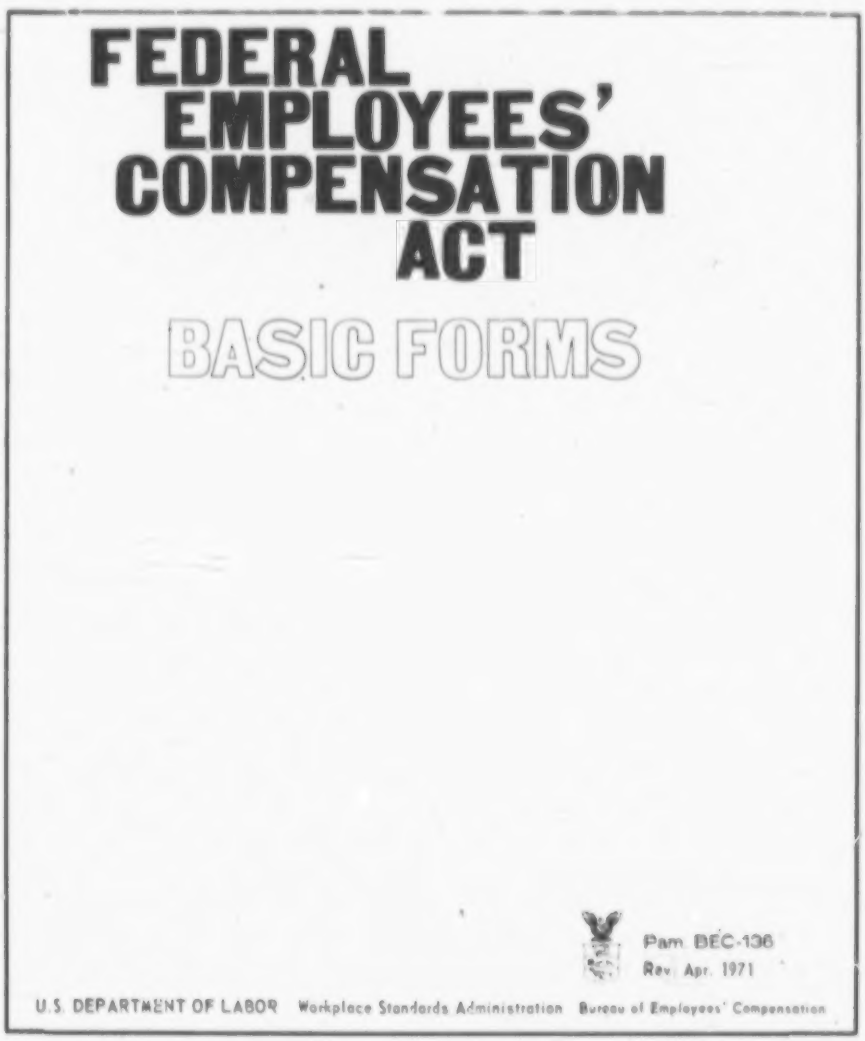
Civil Service Commission (CSC) Forms
- CSC Form 740: Eye Examination, 104
- CSC Form 739: Medical Report (Epilepsy), 106
- CSC Form 3684: Medical Report (Diabetes Mellitus), 107
- CSC Form 4434: Medical Report (Pulmonary Tuberculosis), 108
- CSC Form 3986: Authorization for Release of Medical Records, 110

Other Forms
- Optional Form 58: Report of Medical History, 111
- NAVSO 5100/9: Dispensary Permit, 113

Local Forms and Letters
- Cardiac Followup Sheet, 114
- Diabetic Followup Sheet, 115
- Health Evaluation Procedures, 116
- Humanitarian Emergency Care, 117
- Letter to Physician for Confirmation of Pregnancy and Advisability of Continuing Work, 118
- Medical Followup Card, 118
- Occupational Injury or Illness Report, 119
- Physiotherapy Prescription and Record, 120
- Request for Information from Physician, 121
- Request for Information on Employee Following Recovery from Heart Attack, 122
- Request for Information on Employee Returning to Light Duty, 123

BEC BASIC FORMS AND OTHER SAMPLE FORMS

The following pages contain samples of BEC (Bureau of Employees' Compensation), SF (standard form), and CSC (Civil Service Commission) forms most likely to be used in an occupational health program. The pamphlet *Federal Employees' Compensation Act Basic Forms* published by the Bureau of Employees' Compensation, Department of Labor, is reproduced here as a ready reference. It describes several forms (three are reproduced here) used most frequently in filing claims for workmens' compensation under the Federal Employees' Compensation Act—where these forms may be obtained, why and how they are used, who prepares them, and where they are sent.


FEDERAL EMPLOYEES' COMPENSATION ACT

BASIC FORMS

Pam. BEC-136
Rev. Apr. 1971

U.S. DEPARTMENT OF LABOR Workplace Standards Administration Bureau of Employees' Compensation

This pamphlet has been prepared as a ready reference for administrative offices and supervisors in all agencies. Its purpose is to give brief instructions on the most important forms used in filing claims for workmen's compensation under the Federal Employees' Compensation Act.

This pamphlet does not mention all the forms used in adjudicating claims, nor is it intended to be a substitute for the Bureau's regulations. Other forms, not referred to in this pamphlet, are used for special purposes and will be provided by the Bureau when the need arises.

Additional instructions may be found on the poster CA-10, "What A Federal Employee Should Do When Injured On The Job". This publication should be posted throughout each agency. Pamphlet BEC-11, "When Injured At Work" should be distributed to all employees. Copies of both CA-10 and BEC-11 may be obtained from the appropriate Bureau of Employees' Compensation district office. Another pamphlet, BEC-550, "Work Injury Benefits for Federal Employees", may be purchased from the superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

Forms are ordered from the Bureau of Employees' Compensation. The following agencies stock forms centrally, and in turn supply their respective subordinate offices.

Department of Agriculture
Central Supply Section
Washington, D.C. 20250

Department of the Air Force
Transportation Officer
Air Force Publications Center
2800 Eastern Boulevard
Baltimore, Maryland 21220

Department of the Army
Appropriate AG Publications Center

Department of the Interior
Office of the Secretary
Attn: Chief of the Printing Section
Washington, D.C. 20240

District of Columbia Government
Library Building, Room 225
499 Pennsylvania Avenue, N.W.
Washington, D.C. 20001

Federal Aviation Agency
Aeronautical Center, AC-486.2
P.O. Box 25082
Oklahoma City, Oklahoma 73125

General Services Administration
Regional GSA Office
Distribution Section
Washington, D.C. 20407

Internal Revenue Service
Distribution Section
Washington, D.C. 20224

Office of Economic Opportunity
Management Support Division
1200 19th Street N.W., Room 450
Washington, D.C. 20506

Social Security Administration
Procurement and Property Section
2415 West Franklin Street
Baltimore, Maryland 21223

U.S. Public Health Service
Attn: Chief, Printing Industry
U.S. Public Health Service Hospital
Lexington, Kentucky 40507

Veterans Administration
Distribution Section
Publication Service
Washington, D.C. 20420

All other agencies should obtain forms from the following Bureau of Employees' Compensation office:

BEC Office	
Bureau of Employees' Compensation Washington, D.C. 20211	Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont
Bureau of Employees' Compensation 121 West 44th Street New York, New York 10036	Delaware, New Jersey, New York, and Pennsylvania
Bureau of Employees' Compensation 400 West Bay Street, Box 35049 Jacksonville, Florida 32202	Alabama, Florida, Georgia, North Carolina, South Carolina, and Tennessee
Bureau of Employees' Compensation Federal Office Building, South 600 South Street New Orleans, Louisiana 70130	Arkansas, Louisiana, Mississippi, and Texas
Bureau of Employees' Compensation 1240 East Ninth Street Cleveland, Ohio 44199	Indiana, Kentucky, Michigan, Ohio, and West Virginia
Bureau of Employees' Compensation 536 South Clark Street Chicago, Illinois 60605	Illinois, Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, Oklahoma, South Dakota, and Wisconsin
Bureau of Employees' Compensation 450 Golden Gate Avenue, Box 36022 San Francisco, California 94102	Arizona, California, Colorado, Nevada, and Utah
Bureau of Employees' Compensation Arcade Plaza Building 1321 Second Avenue Seattle, Washington 98101	Alaska, Idaho, Montana, Oregon, Washington, and Wyoming
Bureau of Employees' Compensation 1833 Kalakaua Avenue, Room 610 Honolulu, Hawaii 96815	Hawaii, Pacific area
Bureau of Employees' Compensation 1111 20th Street N. W., Room 812 Washington, D.C. 20211	District of Columbia, foreign countries except Pacific area, Maryland, and Virginia

FORM NO.	FORM TITLE	PURPOSE
CA 1&2	Federal Employee's Notice of Injury or Occupation Disease	Notifies Official Superior or injury and furnishes the Official Superior's report to BEC when (1) the injury is likely to result in any medical charge against the Compensation Fund; or if (2) the injured employee loses time from work on any day following the injury date--whether the time from work is charged to his leave record or not; (3) prolonged treatment is indicated--even if the treatment is received on off-duty hours; (4) disability for work may subsequently occur; (5) permanent disability appears likely; or (6) serious disfigurement of the face, head, or neck is likely to result.
CA-2a	Notice of Recurrence of Disability	Notifies BEC that an employee, after returning to work, is again disabled due to a prior injury or occupational disease previously reported.
CA-3	Report of Termination of Total or Partial Disability; Report of Death	Notifies BEC that disability from injury has terminated; or, notifies BEC when employee dies as a result of the injury.
CA-4	Claim for Compensation on Account of Injury or Occupational Disease.	Claims compensation when injury results in (1) loss of pay for more than 3 days; or (2) permanent disability involving the total or partial loss, or loss of use of an extremety of the body (or hearing or vision) or serious disfigurement of the face, head, or neck; or (3) loss of wage-earning capacity. Claims augmented compensation based on a dependent.
CA-5*	Claim for Compensation on Account of Death	Claims compensation when injury results in death.
CA-8	Claim for Continuance of Compensation on Account of Disability	Claims compensation when loss of pay continues beyond the time covered by the original claim on Form CA-4.
CA-16	Request for Examination and/or Treatment	Authorizes examination and/or treatment of an employee injured (by accident) by a U.S. medical officer or hospital; designated physician; or other qualified physician in the area when neither Federal medical facilities or designated physicians are available or their use is not practicable. Provides BEC with initial medical report. Provides physician or medical facility authorized to provide medical services with billing form for submission of charges.
CA-20*	Attending Physician's Report	Provides medical support of claim on Form CA-4 attached; provides BEC with medical information.
BEC-134	Billing Instructions	Instructs doctors, hospitals, and vendors of medical supplies and appliances how to submit bills.

*This form is not furnished to agencies and will not be stocked by them.

PREPARED BY	WHEN SUBMITTED	COMPLETED FORM SENT TO
Employee or someone on his behalf; witness (if any), Official Superior	By employee within 48 hours; by Official Superior, immediately after the injury or immediately upon receipt of the employee's notice.	Official Superior, by employee or someone on his behalf then to the appropriate BEC office by the Official Superior
Official Superior	Immediately upon receiving notice that the employee has suffered a recurrence.	Appropriate BEC office.
Official Superior	Immediately after the employee returns to work, or immediately after death.	Appropriate BEC office.
Employee or someone on his behalf; Official Superior; and attending physician (on Form CA-20 attached)	In case of prolonged disability the form may be submitted without delay after pay stops. In cases of limited disability it is to be submitted 10 days after pay stops or when the employee returns to work if the disability is less than 10 days and pay was lost for more than 3 days.	Appropriate BEC office
Person claiming compensation; attending physician; and Official Superior	Within 1 month, if possible, but no later than 1 year after death.	Appropriate BEC office
Employee or someone on his behalf; attending physician; and Official Superior	Semi-monthly	Appropriate BEC office
Part A -- Official Superior Part B -- Attending Physican	Part A -- By Official Superior within 48 hours of first examination and/or treatment (in duplicate). Part B -- By attending physician or medical facility as promptly as possible after initial examination.	Part A -- Physician or medical facility. Part B -- Appropriate BEC office.
Examining physician. (After the Official Superior completes items 1 - 4 on the face and the address entry on the reverse of the room.)	Promptly upon completion by physician.	Appropriate BEC office.

INSTRUCTIONS FOR COMPLETING FEDERAL EMPLOYEES' NOTICE OF INJURY *OR OCCUPATIONAL DISEASE,* CA-1 & 2

IMPORTANT: Employee and official superior should read all of the following instructions before the page is removed.

Items 1 through 16 of this form should be completed by the injured employee or by someone acting on his behalf, whenever an injury is sustained in the performance of duty. The term injury includes occupational disease caused by the employment. The form should be given to the employee's official superior within 48 hours following the injury. The official superior is that individual having responsible supervision over the employee.

In instances of a recurrence of disability resulting from an injury previously reported on form CA-1 & 2, the official superior should complete and submit form CA-2a.

The official superior will complete the "Receipt of Notice of Injury" at the bottom of this page, tear off the page, and give it to the employee. The official superior will also be responsible for obtaining the statement of a witness *(if any)*, signature, and date, in items 17, 18 and 19 on the front of the form.

A brief description of benefits provided by the Federal Employees' Compensation Act is given on the back of this page.

INSTRUCTIONS FOR COMPLETING OFFICIAL SUPERIOR'S REPORT OF INJURY *OR OCCUPATIONAL DISEASE,* CA-1 & 2

The back of form CA-1 & 2 should be completed by the employee's official superior. The form should be sent immediately to the office of the Bureau of Employees' Compensation servicing the employing establishment if:

1. The injury causes disability for the employee's usual work beyond the shift it occurred, or
2. It appears that the injury will result in prolonged treatment, permanent disability or serious disfigurement of the head, face or neck, or
3. It appears that the injury will result in a charge for medical or other related expense.

If none of the above occurs or appear likely to occur, the form should be filed in the employee's official personnel file after the official superior completes the "Receipt of Notice of Injury" and gives it to the employee.

When additional information is required to explain or clarify any point, attach supplemental statements to the form. The form should then be sent to the appropriate office of the Bureau. For further information, see the regulations governing the administration of the Federal Employees' Compensation Act (Code of Federal Regulations Title 20 Chapter 1).

RECEIPT OF NOTICE OF INJURY

THIS ACKNOWLEDGES RECEIPT OF NOTICE OF INJURY SUSTAINED BY _____ *(Name of injured employee)*

WHICH OCCURRED ON _____ *(Mo., day, year)* AT _____ *(Location)*

SIGNATURE OF OFFICIAL SUPERIOR	TITLE	DATE *(Mo., day, year)*

CA-1 & 2
Rev. July, 1970

Sample 1. Form CA 1 & 2: Federal employee's notice of injury or occupational disease.

DISABILITY BENEFITS FOR EMPLOYEES UNDER THE FEDERAL EMPLOYEES' COMPENSATION ACT

The Federal Employees' Compensation Act which is administered by the Bureau of Employees' Compensation (BEC) provides the following basic disability benefits for employment related injuries or occupational diseases:

1. Full medical care.
2. Payment of compensation for wage loss.
3. Payment of compensation for permanent impairment of certain members or functions of the body (such as loss or loss of use of an arm, loss of hearing, etc.) or for serious disfigurement of the head, face or neck.
4. Vocational rehabilitation and related services where necessary.

Medical care must be obtained from United States medical officers and hospitals if Practical, or from private physicians designated by the BEC. Other qualified physicians may be used only if U.S. or designated medical facilities are not available, or if an emergency exists.

Compensation is paid by check sent to the employee's home mailing address. Compensation for wage loss is payable only for periods when an employee is in a non-pay status. The first three days in a non-pay status are waiting days and no compensation is paid for these days unless the period of disability exceeds 21 days or the employee has suffered a permanent disability. Compensation is generally paid at the rate of 2/3 of an employee's salary if he has no dependents, or 3/4 of his salary if he has one or more dependents.

Compensation is not paid automatically—an employee or someone acting on his behalf must claim it by filing the BEC form CA-4. This form may be obtained from the employing establishment or the BEC. In practically all cases medical reports are required before compensation may be paid, therefore arrangements should be made to have medical reports submitted to the BEC at the earliest possible date.

If an employee stops work as a result of an employment related injury or occupational disease, he may:

1. Use sick and/or annual leave, or
2. Receive compensation from the BEC.

Before compensation may be paid, the BEC must receive form CA-1 & 2; form CA-4; and medical evidence concerning the nature and causal relationship of the injury. Medical reports must cover initial examination and the employee's condition at the time claim for compensation is filed. In addition, if a case involves some complication or conflicting information, it may be necessary to obtain supplemental information.

An employee or someone acting on his behalf must complete the front of the form CA-1 & 2 and file it within one year after the injury or disease occurs. However, under certain circumstances, the BEC may waive the one-year requirement if the front of the CA-1 & 2 is completed and the form filed within five years.

If an employee is in doubt about his compensation benefits, he may write to the Bureau of Employees' Compensation Office servicing the employing establishment. (Obtain the address of the BEC office from the employing establishment).

Sample 1. Form CA 1 & 2, cont'd.

U.S. DEPARTMENT OF LABOR
WORKPLACE STANDARDS ADMINISTRATION
BUREAU OF EMPLOYEES' COMPENSATION

FEDERAL EMPLOYEE'S NOTICE OF INJURY OR OCCUPATIONAL DISEASE

1. NAME OF INJURED EMPLOYEE (Last, first, middle)	2. DATE OF BIRTH (Mo., day, year)	3. ☐ MALE ☐ FEMALE	4. SOCIAL SECURITY NUMBER

5. HOME MAILING ADDRESS (Number, street, city, state, zip code)	6. HOME TELEPHONE AREA CODE NUMBER

7. NAME AND ADDRESS OF EMPLOYING ESTABLISHMENT (Name, number, street, city, state, zip code)

8. PLACE WHERE INJURY OCCURRED (e.g., 2nd floor, building 402, Andrews Air Force Base)

9. DATE AND HOUR OF INJURY (Mo., day, year) ☐ AM ☐ PM	10. DATE OF THIS NOTICE (Mo., day, year)	11. OCCUPATION

12. CAUSE OF INJURY (Describe how and why injury ocurred)

13. NATURE OF INJURY (Name part of body affected—fractured left leg, bruised right thumb, etc.)

14. NAMES OF WITNESSES TO INJURY (If none, so state)

15. IF THIS NOTICE WAS NOT GIVEN WITHIN 48 HOURS AFTER THE INJURY, EXPLAIN REASON FOR DELAY. IF EARLIER NOTICE WAS GIVEN VERBAL OR WRITTEN, STATE WHEN AND TO WHOM.

I certify that the injury described above was sustained in the performance of my duties as an employee of the U.S. Government and that it was not caused by my willful misconduct, intention to bring about the injury or death of myself, or another, nor by my intoxication. I hereby make claim for compensation and medical treatment to which I may be entitled by reason of this injury.	16. SIGNATURE OF INJURED EMPLOYEE OR PERSON ACTING ON HIS BEHALF

17. STATEMENT OF WITNESS: DESCRIBE WHAT YOU SAW, HEARD OR KNOW ABOUT THIS INJURY

18. SIGNATURE OF WITNESS	19. DATE (Mo., day, year)

CA-1 & 2
Rev. July, 1970

Sample 1. Form CA 1 & 2, cont'd.

FEDERAL EMPLOYEE'S NOTICE OF INJURY OR OCCUPATIONAL DISEASE

20. DEPARTMENT OR AGENCY	21. BUREAU OR OFFICE

22. NAME AND MAILING ADDRESS OF REPORTING OFFICE *(Name, number, street, city, state, zip code)*

23. DATE REPORTING OFFICE RECEIVED NOTICE OF INJURY *(Mo., day, year)* ☐ VERBAL ☐ WRITTEN	24. NAME OF SUPERVISOR IN CHARGE WHEN INJURY OCCURRED	25. NAME AND TITLE OF PERSON TO WHOM NOTICE FIRST GIVEN

26. DATE AND HOUR OF INJURY *(Mo., day, year)* ☐ AM ☐ PM	27. CIRCLE DAY OF WEEK WHEN INJURY OCCURRED S M T W T F S	28. HOUR REGULAR WORK BEGINS ☐ AM ☐ PM

29. HOUR REGULAR WORK ENDS ☐ AM ☐ PM	30. NUMBER HOURS WORKED PER DAY	31. CIRCLE DAYS PAID PER WEEK S M T W T F S

32. DATE AND HOUR STOPPED WORK *(Mo., day, year)* ☐ AM ☐ PM	33. DATE AND HOUR PAY STOPPED *(Mo., day, year)* ☐ AM ☐ PM	34. DATE AND HOUR RETURNED TO WORK *(Mo., day, year)* ☐ AM ☐ PM

35. INCLUSIVE DATES EMPLOYEE RECEIVED PAY FOR THE PERIOD HE DID NOT WORK *(Mo., day, year)*

ANNUAL LEAVE		SICK LEAVE		OTHER	
FROM	TO	FROM	TO	FROM	TO
FROM	TO	FROM	TO	FROM	TO
FROM	TO	FROM	TO	FROM	TO

36. WAS THE EMPLOYEE ENGAGED IN HIS USUAL OCCUPATION AT THE TIME THE INJURY OCCURRED? ☐ YES ☐ NO IF NO, FURNISH DETAILED EXPLANATION

37. WAS THE EMPLOYEE IN PERFORMANCE OF DUTY AT TIME OF INJURY? ☐ YES ☐ NO IF NO, FURNISH DETAILED EXPLANATION OR A COPY OF THE EMPLOYING ESTABLISHMENT'S INVESTIGATION REPORT

38. WAS THE INJURY CAUSED BY WILLFUL MISCONDUCT, INTOXICATION OR INTENT TO BRING ABOUT INJURY TO SELF OR ANOTHER? ☐ YES ☐ NO IF YES, FURNISH DETAILED EXPLANATION

39. WAS THE INJURY CAUSED BY A THIRD PARTY? ☐ YES ☐ NO IF YES, FURNISH NAME AND ADDRESS OF RESPONSIBLE PARTY

40. DATE EMPLOYEE FIRST OBTAINED MEDICAL CARE FOR THE INJURY *(Mo., day, year)*	41. NAME AND ADDRESS OF FIRST ATTENDING PHYSICIAN

42. DOES YOUR KNOWLEDGE OF THE FACTS ABOUT THIS INJURY AGREE WITH THE STATEMENTS OF THE EMPLOYEE AND/OR WITNESS? ☐ YES ☐ NO IF NO, FURNISH DETAILED EXPLANATION

43. SIGNATURE OF OFFICIAL SUPERIOR	44. TITLE	45. DATE *(Mo., day, year)*

CA-1 & 2
Rev. July, 1970

Sample 1. Form CA 1 & 2, cont'd.

U. S. DEPARTMENT OF LABOR
WORK PLACE STANDARDS ADMINISTRATION
BUREAU OF EMPLOYEES' COMPENSATION

NOTICE OF
RECURRENCE OF DISABILITY

IMPORTANT: BEFORE COMPLETING THIS FORM PLEASE READ CAREFULLY THE INSTRUCTIONS ON THE BACK.

1. NAME OF INJURED EMPLOYEE (last, first, middle)	2. DATE AND HOUR of original injury (mo., day, year) ☐ a.m. ☐ p.m.	3. BEC file number for original injury (If known)
4. HOME MAILING ADDRESS (number, street, city, state, zip code)		5. HOME TELEPHONE Area Code Number
6. NAME AND ADDRESS OF EMPLOYING ESTABLISHMENT at time of original injury (number, street, city, state, zip code)	7. NAME AND ADDRESS OF EMPLOYING ESTABLISHMENT at time of recurrence, if other than 6.	
8. DATE AND HOUR of recurrence. (mo., day, year) ☐ a.m. ☐ p.m.	9. DATE AND HOUR stopped work following recurrence (mo., day, year) ☐ a.m. ☐ p.m.	10. DATE AND HOUR pay stopped following recurrence (mo., day, year) ☐ a.m. ☐ p.m.

11. PAY RATE IN EFFECT ON:	a. Base Pay	b. Subsistance	c. Quarters	d. Other pay
A. Date of Recurrence	$ per	$ per	$ per	$ per
B. Date Stopped Work Following Recurrence	$ per	$ per	$ per	$ per

12. Show work week at time pay stopped, if other than Monday thru Friday S M T W T F S	13. DATE AND HOUR returned to work, following recurrence (mo., day, year) ☐ a.m. ☐ p.m.	14. At time of recurrence did official superior authorize medical treatment? ☐ YES ☐ NO
15. DATE employee first received medical treatment following recurrence (mo., day, year)	16. NAME AND ADDRESS of physician treating employee following recurrence.	

17. Describe the circumstances of the recurrence of disability as reported by the employee. If his condition gradually worsened over a period of time, describe the progress of the condition from the time he returned to work up to the date of recurrence.

18. After returning to work following the original injury, was the employee handicapped or in any way limited in performing his usual duties? ☐ YES ☐ NO (If yes, explain)

19. Signature of official superior (at time of recurrence)	20. Title	21. Official superior's work phone number	22. DATE (mo., day, year)

CA-2a
Rev. July 1970

Sample 2. Form CA-2a: Notice of recurrence of disability.

INSTRUCTIONS FOR COMPLETING FORM CA-2a

RECURRENCE OF DISABILITY

Definition of Recurrence: When, after returning to work, an injured employee is again disabled and stops work as a result of the original injury or occupational disease , such disability is considered by the Bureau to be a recurrence. In these instances a form CA-2a is required. If a new incident occurs, the matter should be treated as a new injury and form CA-1 & 2, etc., submitted accordingly.

1. Form CA-2a should be submitted promptly by the official superior upon receiving notice that the employee has suffered a recurrence.

2. If the original injury was not previously reported to BEC, a report specifically covering the original injury should be made on form CA-1&2 and attached when form CA-2a is submitted. Medical reports concerning the original injury should also be attached, if not previously submitted.

3. When the employee has received medical care as a result of the recurrence, a detailed medical report should be submitted by the attending physician. The report should include: dates of examination and treatment; history given by the employee; findings; results of x-ray and lab tests; diagnosis; course of treatment, and the physician's opinion regarding causal relationship between employee's condition and the original injury.

   If the employee was treated by other physicians after returning to work following his original injury, similar medical reports should be obtained from each.

4. If the recurrence happened six months or more after the employee returned to duty following the original injury, a statement from the employee should accompany the form CA-2a. The statement should describe the employee's duties upon his return to work, state whether he had any other injuries or illness and give a general description of his physical condition during the intervening period.

5. If the employee wishes to claim compensation as a result of the recurrance, a form CA-4 is required, whether or not one was submitted following the original injury. All parts of the form CA-4, plus a medical report on form CA-20 (or in narrative form) must be completed in accordance with the applicable instructions.

6. If the recurrent disability has not ended at the time form CA-2a is submitted, form CA-3, Termination of Disability, should be forwarded when the employee returns to work.

7. In the event the employee is not able to return to his same duties and suffers pay loss as a result of his disability, he may be entitled to additional compensation based on loss of wages, or loss of wage earning capacity. Upon notification of such loss, the BEC will advise the employee of the procedure to follow to claim additional compensation.

Sample 2. Form CA-2a, cont'd.

U.S. DEPARTMENT OF LABOR Workplace Standards Administration Bureau of Employees' Compensation	REQUEST FOR EXAMINATION AND/OR TREATMENT

PART A - AUTHORIZATION

INSTRUCTIONS TO AUTHORIZING OFFICIAL. This side of Form CA-16 shall be completed in full to authorize a medical officer of the United States, a designated physician, or other qualified physician to examine and/or treat a Federal employee for a personal injury sustained in the performance of duty. This form shall not be issued for disease or illness *(in instances of disease or illness the appropriate district office of the Bureau of Employees' Compensation shall be contacted for instructions)*. Judgment is necessary in checking box "A" or box "B" in item 6. Also, in item 11 the address of the proper office of the Bureau of Employees' Compensation shall be shown. Send an original and one copy of this form to the medical officer or physician.

1. NAME AND ADDRESS OF THE MEDICAL FACILITY OR PHYSICIAN AUTHORIZED TO PROVIDE THE MEDICAL SERVICE

2. EMPLOYEE'S NAME *(Last, first, middle)*	3. DATE OF INJURY *(Mo., day, yr.)*	4. OCCUPATION

5. DESCRIPTION OF INJURY

6. YOU ARE AUTHORIZED TO PROVIDE MEDICAL SERVICE TO THIS EMPLOYEE SUBJECT TO THE FOLLOWING CONDITIONS.

☐ A- Furnish office and/or hospital treatment as necessary for the effects of this injury. Any surgery, other than emergency, must have prior BEC approval.

☐ B-There is doubt whether the employee's impairment is caused by an injury sustained in the performance of duty. You are authorized to examine the employee, using indicated non-surgical diagnostic studies, and promptly advise the undersigned whether you believe the disability is due to the alleged injury. Pending further advice, you may provide necessary conservative treatment if you believe the impairment may be due to the injury.

YOU ARE ALSO REQUESTED TO SUBMIT A WRITTEN REPORT TO THE OFFICE OF THE BUREAU OF EMPLOYEES' COMPENSATION NAMED IN ITEM 11 BELOW *(See instruction for completing your report and submitting your charges on the back of this form)*.

7. SIGNATURE OF AUTHORIZING OFFICIAL *(Sign all copies)*	8. TITLE
9. LOCAL TELEPHONE NUMBER	10. DATE *(Mo., day, yr.)*
11. SEND ONE COPY OF YOUR REPORT TO *(Fill in address)*: U.S. DEPARTMENT OF LABOR Wage and Labor Standards Administration Bureau of Employees' Compensation	12. NAME AND ADDRESS OF EMPLOYEE'S PLACE OF EMPLOYMENT *Dept.* *Bureau* *Local Address*

Form CA-16
(REV. 7-70)

Sample 3. Form CA-16: Request for examination and/or treatment.

PART B – ATTENDING PHYSICIAN'S REPORT

INSTRUCTIONS TO PHYSICIAN. As promptly as possible after you examine this employee (FIRST SEE ITEM 6 ON THE FRONT OF THIS FORM) submit a medical report to the Bureau of Employees' Compensation. It may be made by responding to items 13 through 33 below or in narrative form. If a narrative report is made, attach it to this form. Your itemized bill may also be submitted by completing item 34 below or on your billhead stationery. If there is prolonged disability, supplemental narrative reports should be submitted at monthly intervals, accompanied by your bills.

13. WHAT HISTORY OF INJURY *(Including disease caused by the employment)* DID EMPLOYEE GIVE YOU?

14. WHAT ARE YOUR FINDINGS *(Include results of x-rays, laboratory tests, etc.)*?

15. WHAT IS YOUR DIAGNOSIS?

16. DO YOU BELIEVE THIS DISABILITY IS IN ANY WAY RELATED TO THE HISTORY OF THE INJURY AS GIVEN ABOVE? *(Please explain your answer if there are doubts)*
☐ YES ☐ NO

17. DID INJURY REQUIRE HOSPITALIZATION? ☐ YES ☐ NO
IF YES, DATE OF ADMISSION *(Mo., day, year)*
DATE OF DISCHARGE

18. IS ADDITIONAL HOSPITALIZATION REQUIRED?
☐ YES ☐ NO

19. OPERATIONS *(If any, describe type)*

20. DATE OPERATIONS PERFORMED *(Mo., day, year)*

21. WHAT *(Other)* TYPE OF TREATMENT DID YOU PROVIDE?

22. WHAT PERMANENT EFFECTS, IF ANY, DO YOU ANTICIPATE?

23. DATE OF FIRST EXAMINATION *(Mo., day, year)*

24. DATES OF TREATMENT *(Mo., day, year)*

25. DATE OF DISCHARGE FROM TREATMENT *(Mo., day, year)*

26. PERIOD OF DISABILITY *(If termination date unknown-so indicate)* *(Mo, day, year)*
TOTAL DISABILITY: FROM TO
PARTIAL DISABILITY: FROM TO

27. DATE EMPLOYEE ABLE TO RESUME WORK *(Mo., day, year)*
LIGHT WORK
REGULAR WORK

28. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE BEEN ADVISED? ☐ YES ☐ NO IF YES, FURNISH DATE ADVISED

29. IF EMPLOYEE IS ABLE TO RESUME ONLY LIGHT WORK, INDICATE THE EXTENT OF HIS PHYSICAL LIMITATIONS AND THE TYPE OF WORK HE COULD REASONABLY PERFORM WITH THESE LIMITATIONS.

30. GENERAL REMARKS AND RECOMMENDATIONS FOR FUTURE CARE, IF INDICATED.

31. SIGNATURE OF PHYSICIAN

32. ADDRESS *(Number, street, city, state, zip code)*

33. DATE OF REPORT *(Mo., day, year)*

34. MEDICAL BILL. Charges for your services may be presented in the space below or on your billhead stationery.

Date or period of treatment	Services or supplies must be itemized (Please explain fully reason for any differences in charges on different dates)	Quantity or number	Unit price		Amount	
			Cost	Per	$	¢
	TOTAL →					

GPO 894-187

Sample 3. Form CA-16, cont'd.

TO BE GIVEN TO PERSON EXAMINED WITH A PRE-ADDRESSED "CONFIDENTIAL-MEDICAL" ENVELOPE.

UNITED STATES CIVIL SERVICE COMMISSION
CERTIFICATE OF MEDICAL EXAMINATION

Form Approved
Budget Bureau
No. 50-R0073

Part A. TO BE COMPLETED BY APPLICANT OR EMPLOYEE *(typewrite or print in ink)*

1. NAME *(last, first, middle)*	2. SOCIAL SECURITY ACCOUNT NO.	3. SEX ☐ MALE ☐ FEMALE	4. DATE OF BIRTH

5. DO YOU HAVE ANY MEDICAL DISORDER OR PHYSICAL IMPAIRMENT WHICH WOULD INTERFERE IN ANY WAY WITH THE FULL PERFORMANCE OF THE DUTIES SHOWN BELOW?
☐ YES ☐ NO
(If your answer is "YES" explain fully to the physician performing the examination)

6. I CERTIFY THAT ALL THE INFORMATION GIVEN BY ME IN CONNECTION WITH THIS EXAMINATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____
(signature of applicant)

Part B. TO BE COMPLETED BEFORE EXAMINATION BY APPOINTING OFFICER

1. PURPOSE OF EXAMINATION
☐ PREAPPOINTMENT
☐ OTHER *(specify)*

2. POSITION TITLE

3. BRIEF DESCRIPTION OF WHAT POSITION REQUIRES EMPLOYEE TO DO

4. Circle the number preceding *each* functional requirement and *each* environmental factor essential to the duties of this position. List any additional essential factors in the blank spaces. Also, if the position involves law enforcement, air traffic control, or fire fighting, attach the specific medical standards for the information of the examining physician.

A. FUNCTIONAL REQUIREMENTS

1. Heavy lifting, 45 pounds and over
2. Moderate lifting, 15–44 pounds
3. Light lifting, under 15 pounds
4. Heavy carrying, 45 pounds and over
5. Moderate carrying, 15–44 pounds
6. Light carrying, under 15 pounds
7. Straight pulling (hours)
8. Pulling hand over hand (hours)
9. Pushing (hours)
10. Reaching above shoulder
11. Use of fingers
12. Both hands required
13. Walking (hours)
14. Standing (hours)
15. Crawling (hours)
16. Kneeling (hours)
17. Repeated bending (hours)
18. Climbing, legs only (hours)
19. Climbing, use of legs and arms
20. Both legs required
21. Operation of crane, truck, tractor, or motor vehicle
22. Ability for rapid mental and muscular coordination simultaneously
23. Ability to use and desirability of using firearms
24. Near vision correctable at 13" to 16" to Jaeger 1 to 4
25. Far vision correctable in one eye to 20/20 and to 20/40 in the other
26. Far vision correctable in one eye to 20/50 and to 20/100 in the other
27. Specific visual requirement *(specify)*
28. Both eyes required
29. Depth perception
30. Ability to distinguish basic colors
31. Ability to distinguish shades of colors
32. Hearing *(aid permitted)*
33. Hearing without aid
34. Specific hearing requirements (specify)
35. Other *(specify)*

B. ENVIRONMENTAL FACTORS

1. Outside
2. Outside and inside
3. Excessive heat
4. Excessive cold
5. Excessive humidity
6. Excessive dampness or chilling
7. Dry atmospheric conditions
8. Excessive noise, intermittent
9. Constant noise
10. Dust
11. Silica, asbestos, etc.
12. Fumes, smoke, or gases
13. Solvents *(degreasing agents)*
14. Grease and oils
15. Radiant energy
16. Electrical energy
17. Slippery or uneven walking surfaces
18. Working around machinery with moving parts
19. Working around moving objects or vehicles
20. Working on ladders or scaffolding
21. Working below ground
22. Unusual fatigue factors *(specify)*
23. Working with hands in water
24. Explosives
25. Vibration
26. Working closely with others
27. Working alone
28. Protracted or irregular hours of work
29. Other *(specify)*

Part C. TO BE COMPLETED BY EXAMINING PHYSICIAN

1. EXAMINING PHYSICIAN'S NAME *(type or print)*	3. SIGNATURE OF EXAMINING PHYSICIAN
2. ADDRESS *(including ZIP Code)*	_____ *(signature)* _____ *(date)*

IMPORTANT: After signing, return *the entire form intact* in the pre-addressed "Confidential-Medical" envelope which the person you examined gave you.

78-110

STANDARD FORM NO. 78
OCTOBER 1969 (REVISION)
CIVIL SERVICE COMM'SSION
FPM 339

Sample 4. SF-78: Certificate of medical examination.

NOTE TO EXAMINING PHYSICIAN: The person you are about to examine will have to cope with the functional requirements and environmental factors circled on the other side of this form. Please take them, and the brief description of job duties above them, into consideration as you make your examination and report your findings and conclusions.

1. HEIGHT: _____ FEET, _____ INCHES. WEIGHT: _____ POUNDS.

2. EYES:

(A) Distant vision (Snellen): without glasses: right $\frac{20}{\quad}$ left $\frac{20}{\quad}$; with glasses, if worn: right $\frac{20}{\quad}$ left $\frac{20}{\quad}$

(B) What is the longest and shortest distance at which the following specimen of Jaeger No. 2 type can be read by the applicant? Test each eye separately.

Jaeger No. 2 Type

employees in the Federal classified service as may be requested by the Civil Service Commission or its authorized representative. This order will supplement the Executive Orders of May 29 and June 18, 1923 (Executive Order, September 4, 1924).

	without glasses:	with glasses, if used:
R.	_____ in. to _____ in.	_____ in. to _____ in.
L.	_____ in. to _____ in.	_____ in. to _____ in.

(C) Color vision: Is color vision normal when Ishihara or other color plate test is used? ☐ YES ☐ NO
If not, can applicant pass lantern, yarn, or other comparable test? ☐ YES ☐ NO

3. EARS: (Consider denominators indicated here as normal. Record as numerators the greatest distance heard.)
Ordinary conversation:

RIGHT EAR _____ / 20 ft.; LEFT EAR _____ / 20 ft.

Audiometer *(if given)*:

250	500	1000	2000	3000	4000	5000	6000	7000	8000

4. OTHER FINDINGS: In items a through l briefly describe any *abnormality* (including diseases, scars, and disfigurations). Include brief history, if pertinent. If normal, so indicate.

a. Eyes, ears, nose, and throat *(including tooth and oral hygiene)*

b. Head and back *(including face, hair, and scalp)*

c. Speech *(note any malfunction)*

d. Skin and lymph nodes *(including thyroid gland)*

e. Abdomen

f. Peripheral blood vessels

g. Extremities

h. Urinalysis *(if indicated)*
Sp. gr. _____ Sugar _____ Blood _____
Albumen _____ Casts _____ Pus _____

i. Respiratory tract *(X-ray if indicated)*

j. Heart *(size, rate, rhythm, function)*
Blood pressure _____
Pulse _____
EKG *(if indicated)*

k. Back *(special consideration for positions involving heavy lifting and other strenuous duties)*

l. Neurological and mental health

CONCLUSIONS: Summarize below any medical findings which, in your opinion, would limit this person's performance of the job duties and/or would make him a hazard to himself or others. If none, so indicate.

☐ No limiting conditions for this job
☐ Limiting conditions as follows:

Sample 4. SF-78, cont'd.

FOR AGENCY USE ONLY

Part A. TO BE COMPLETED BY APPLICANT OR EMPLOYEE *(typewrite or print in ink)*

1. NAME *(last, first, middle)*	2. SOCIAL SECURITY ACCOUNT NO.	3. SEX ☐ MALE ☐ FEMALE	4. DATE OF BIRTH

5. DO YOU HAVE ANY MEDICAL DISORDER OR PHYSICAL IMPAIRMENT WHICH WOULD INTERFERE IN ANY WAY WITH THE FULL PERFORMANCE OF THE DUTIES SHOWN BELOW? ☐ YES ☐ NO *(If your answer is "YES" explain fully to the physician performing the examination)*	6. I CERTIFY THAT ALL THE INFORMATION GIVEN BY ME IN CONNECTION WITH THIS EXAMINATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. _____ *(signature of applicant)*

Part D. TO BE COMPLETED BY AGENCY MEDICAL OFFICER *(if one is available)*

NOTE: Review the attached certificate of medical examination and make your recommendations in item 1 below. If the medical examination was done for pre-appointment purposes, circle the appropriate handicap code in part F.

1. RECOMENDATION:
☐ HIRE OR RETAIN. DESCRIBE LIMITATIONS, IF ANY, HERE.

☐ TAKE ACTION TO SEPARATE OR DO NOT HIRE. EXPLAIN WHY.

2. AGENCY MEDICAL OFFICER'S NAME *(type or print)*	3. LOCATION *(city, State, ZIP Code)*	4. DATE

Part E. TO BE COMPLETED BY AGENCY PERSONNEL OFFICER

NOTE: Enter the action taken below. If this form is used for pre-appointment purposes, be sure the appropriate handicap code in part F is circled. *IMPORTANT: See FPM Chapter 293, Subchapter 3; FPM Chapter 339; and FPM Supplement 339–31 for disposition and/or filing of both parts of this form, either separately or together.*

1. ACTION TAKEN:
☐ HIRED OR RETAINED. ☐ NON-SELECTED FOR APPOINTMENT, OR ELIGIBILITY OBJECTED TO.
☐ ACTION TAKEN TO SEPARATE.

2. AGENCY PERSONNEL OFFICER'S NAME *(type or print)*	3. SIGNATURE	4. DATE

Part F. HANDICAP CODE *(to be completed only in pre-appointment cases)*

If the person examined has or had a handicap listed below, circle the code number which pertains to that handicap. If more than one handicap applies, circle the one considered most limiting. If none of the handicap codes apply, circle code "00".

00 No handicap of the type listed
10 Amputation—one major extremity
11 Amputation—two or more major extremities
20 Deformity or impaired function—upper extremity
21 Deformity or impaired function—lower extremity or back
30 Vision—one eye only
31 No usable vision
40 Hearing aid required
41 No usable hearing
42 No usable hearing, with speech malfunction
43 Normal hearing, with speech malfunction
50 Tuberculosis—inactive pulmonary
51 Organic heart disease *(compensated)*—valvular, arrhythmia, arteriosclerosis, healed coronary lesions
52 Diabetes—controlled
53 Epilepsy—adequately controlled
54 History of emotional behavioral problems requiring special placement effort
55 Mentally retarded
56 Mentally restored

1. EXAMINING PHYSICIAN'S NAME *(type or print)*	3. SIGNATURE OF EXAMINING PHYSICIAN
2. ADDRESS *(including ZIP Code)*	_____ *(signature)* _____ *(date)* IMPORTANT: After signing, return *the entire form intact* in the pre-addressed "Confidential-Medical" envelope which the person you examined gave you.

Sample 4. SF-78, cont'd.

UNITED STATES CIVIL SERVICE COMMISSION

Budget Bureau
Approved 50-RO392

STATEMENT OF PHYSICAL ABILITY FOR LIGHT DUTY WORK

INSTRUCTIONS TO APPLICANT

Please read instructions for each section carefully before answering the questions. Type or print answers in ink. If additional details are required, use Section D. After completing this statement, be sure to sign your name and give the date in Section E. Your replies will be evaluated in terms of the particular position for which you are applying. (AT THE DISCRETION OF THE APPOINTING OFFICER, A MEDICAL EXAMINATION MAY BE REQUIRED.)

IDENTIFICATION OF APPLICANT

NAME *(Last, First, Middle)*	DATE OF BIRTH *(Mo., Day, Yr.)*	SOCIAL SECURITY NUMBER
ADDRESS *(Number, Street, City, State and ZIP Code)*	TITLE OF POSITION APPLIED FOR	

SECTION A—PHYSICAL LIMITATIONS

Answer each *circled* item "YES" or "NO" by placing an "X" in the proper box below. If you answer "*YES*" to any circled item, give additional details in Section D.

	YES	NO
1. Do you have any problem:		
(a) reading small newspaper print (glasses permitted)?		
(b) reading ordinary newspaper headlines without glasses?		
(c) seeing distant objects with either eye (glasses permitted)?		
2. Do you have difficulty in distinguishing basic colors (red, green, blue)?		
3. Do you have difficulty in distinguishing shades of colors?		
4. Do you have any hearing problem, including hearing telephone conversations (hearing aid permitted)?		
5. Do you wear a hearing aid?		
6. Do you have any speech impairment which hinders:		
(a) person-to-person conversation?		
(b) telephone conversation?		
(c) talking to groups of people?		
7. Do you have an amputation or abnormality of a leg, foot, arm, hand, and/or finger?		
8. Do you have difficulty in using arms, hands, or fingers for reaching in any direction, grasping, handling, or fingering?		
9. Do you have any disease or disability which would make your employment in light duty work a hazard to yourself or others?		

SECTION B—PHYSICAL ENDURANCE FACTORS

Answer each *circled* item "YES" or "NO" by placing an "X" in the proper box to show your physical ability to carry out the listed activities during each work day. If you answer "*NO*" to any item, give additional details in Section D.

DURING THE WORK DAY ARE YOU PHYSICALLY ABLE TO PERFORM ACTIVITIES INVOLVING:	YES	NO
1. Sitting for long periods of time?		
2. Standing for long periods of time?		
3. Some walking on flat surfaces, slight inclines, and occasionally climbing stairs?		
4. Frequent walking and/or climbing of stairs or steep inclines?		
5. Occasional pushing and pulling motions as needed? (For example, opening and closing doors, drawers, etc.)		
6. Frequent pushing and pulling motions? (For example, frequent opening and closing file drawers)		
7. Occasional bending, stooping, and crouching? (For example, reaching the bottom shelf of a supply cabinet)		
8. Frequent bending, stooping, and crouching? (For example, frequently opening and closing lower file drawers)		
9. Occasionally lifting objects weighing up to 10–12 lbs. and frequently carrying lightweight items? (For example, ledgers, dockets, or lightweight equipment)		
10. Occasionally lifting objects weighing up to 20–25 lbs. and frequently carrying objects weighing up to 10–12 lbs.?		

S/N 0109-201-0240

(CONTINUED ON REVERSE SIDE)

Standard Form 177
May 1968
U.S. Civil Service Commission
FPM Chapter 339
177-101

Sample 5. SF-177: Statement of physical ability for light duty work.

SECTION C—ENVIRONMENTAL ENDURANCE FACTORS

Some positions may involve unusual working conditions or working outside. Answer each *circled* item "YES" or "NO" by placing an "X" in the proper box. If you answer *"NO"* to any circled item give additional details in Section D.

Can you work under the following conditions:	YES	NO
1. Outside (frequently)		
2. Severe heat		
3. Severe cold		
4. Severe humidity		
5. Severe dampness or chilling		
6. Dry atmospheric conditions		
7. Severe noise		
8. Constant noise		
9. Dusty atmospheres		
10. Some exposure to fumes, smoke, or gases		
11. Some contact with solvents, greases, and oils		
12. Occasional walking over rough terrain		
13. Some climbing of short ladders (For example, to reach upper supply shelves)		
14. Working below ground surface		
15. Working alone		
16. Occasional travel		
17. Frequent travel		

SECTION D—ADDITIONAL DETAILS

This space is for detailed answers to Sections A, B, and C. (Give item No. & Section letter)

Item No.		Item No.	

IF YOU NEED MORE SPACE, ATTACH ADDITIONAL SHEETS

SECTION E—CERTIFICATION BY APPLICANT

I CERTIFY that all the information I have furnished is correct to the best of my knowledge and belief.

(Applicant's Signature) *(Date)*

SECTION F—FOR AGENCY USE ONLY

1. POSITION TO WHICH APPLICANT ASSIGNED	2. OTHER ACTION TAKEN	3. CODE

4. DATE	5. SIGNATURE OF APPOINTING OFFICER	6. OFFICIAL TITLE

7. DEPARTMENT OR AGENCY	8. ADDRESS OF AGENCY

Sample 5. SF-177, cont'd.

UNITED STATES CIVIL SERVICE COMMISSION

STATEMENT OF PHYSICAL ABILITY FOR LIGHT DUTY WORK

INSTRUCTIONS TO AGENCY

This statement is to be used in lieu of a Certificate of Medical Examination for General Schedule and Schedule B positions whose maximum physical requirements do not exceed those identified on the questionnaire, and may properly be evaluated by an appointing officer.

If, either as a result of replies on the statement, or of personal observation, the appointing officer believes the applicant is physically unable to do the job or would create a hazard to himself or others, the appointing officer may require the applicant to undergo a medical examination as a prerequisite to employment in the position. (The examination may not be required solely on the basis of the applicant's age, sex, or other non-job related factor.) In addition, for positions having unusual sight or hearing requirements, an appropriate specialized examination may be required.

In all cases, the statement should be completed and reviewed prior to employment and before the applicant incurs any expense in traveling a distance to a duty station.

Completed statements may be disposed of as soon as they have served the purpose of the appointing officer, UNLESS item 4, below, applies.

COMPLETING AND REVIEWING THE STATEMENT

1. Fill in "Title of Position Applied For" under "IDENTIFICATION OF APPLICANT."
2. Circle in *RED* the ***item number*** of the questions, in each section, which will determine the applicant's physical ability to perform the duties of the position. Circle ONLY those items which pertain to the physical requirements of the job, or in the case of Section C, the environmental factors. (Consult Handbook X-118, "Qualification Standards for Classification Act Positions," or applicable agency standard for the physical requirements for series of positions.)
3. After the applicant completes the statement, take appropriate action as indicated by the applicant's replies. *A Federal medical officer should be consulted when indicated by detailed replies.* Complete item 3, Section F, "FOR AGENCY USE ONLY," by entering the appropriate handicap code. The list of handicaps and corresponding codes is on the reverse side of these instructions.
4. If the appointing officer feels that the applicant may not meet the physical qualifications and wishes to object to him as an eligible or, if he is a preference eligible, to pass him over on that ground, he must request a medical examination. He must then submit the entire record (including the Certificate of Medical Examination, SF 78; the Statement of Physical Ability for Light Duty Work, SF 177; and, if available, the Personal Qualifications Statement, SF 171) to the Commission for a decision, with his Statement of Reasons for Objecting to an Eligible or Passing Over a Preference Eligible, SF 62.

TEAR OFF THIS SHEET BEFORE GIVING THE STATEMENT TO THE APPLICANT TO COMPLETE.

Sample 5. SF-177, cont'd.

HANDICAP CODES AND INSTRUCTIONS

(Note carefully numbers and definitions)

CODE		CODE	
00	No handicap of the type listed.	43	Normal hearing with speech malfunction.
10	Amputation—one major extremity.	50	Tuberculosis—inactive pulmonary.
11	Amputation—two or more major extremities.	51	Organic heart disease (compensated)—valvular, arrhythmia, arteriosclerosis, healed coronary lesions.
20	Deformity or impaired function—upper extremity.	52	Diabetes—controlled.
21	Deformity or impaired function—lower extremity or back.	53	Epilepsy—adequately controlled.
30	Vision—one eye only.	54	History of emotional or behavioral problems requiring special placement effort.
31	No usable vision.	55	Mentally retarded.
40	Hearing aid required.	56	Mentally restored.
41	No usable hearing.		
42	No usable hearing with speech malfunction.		

If the applicant indicates that he has or has had a handicap which is listed above, enter the corresponding code number in item 3, Section E, "FOR AGENCY USE ONLY." If more than one handicap applies, enter the one you consider most limiting. If none of the handicaps apply, enter code "00".

D-16788

Sample 5. SF-177, cont'd.

STANDARD FORM 93
JANUARY 1971
GSA FPMR 101–11.8

Approved
Office of Management and Budget No. 29–R0191

REPORT OF MEDICAL HISTORY

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME		2. SOCIAL SECURITY OR IDENTIFICATION NO.
3. HOME ADDRESS *(No. street or RFD, city or town, State, and ZIP CODE)*		4. POSITION *(Title, grade, component)*
5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION	7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS *(Include ZIP Code)*

8. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint exists)*

9. HAVE YOU EVER *(Please check each item)*

YES	NO	*(Check each item)*
		Lived with anyone who had tuberculosis
		Coughed up blo[od]
		Bled excessively [af]ter injury or tooth extraction
		Attempted suicid[e]
		Been a sleepwalk[er]

10. DO YOU *(Please check each item)*

YES	NO	*(Check each item)*
		Wear glasses or contact lenses
		Have vision in both eyes
		Wear a hearing aid
		Stutter or stammer habitually
		Wear a brace or back support

11. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	*(Check each item)*	YES	NO	DON'T KNOW	*(Check each item)*	YES	NO	DON'T KNOW	*(Check each item)*
			Scarlet fever, erysipelas				Cramps in your legs				"Trick" or locked knee
			Rheumatic fever				Frequent indigestion				Foot trouble
			Swollen or painful joints				Stomach, liver, or intestinal trouble				Neuritis
			Frequent or severe headache				Gall bladder trouble or gallstones				Paralysis (include infantile)
			Dizziness or fainting spells				Jaundice or hepatitis				Epilepsy or fits
			Eye trouble				Adverse reaction to serum, drug,				Car, train, sea or air sickness
			Ear, nose, or thr[o]t trouble				or medicine				Frequent trouble sleeping
			Hearing loss				Broken bones				Depression or excessive worry
			Chronic or frequent colds				Tumor, growth, cyst, cancer				Loss of memory or amnesia
			Severe tooth or gum trouble				Rupture/hernia				Nervous trouble of any sort
			Sinusitis				Piles or rectal disease				Periods of unconsciousness
			Hay Fever				Frequent or painful urination				
			Head injury				Bed wetting since age 12				
			Skin diseases				Kidney stone or blood in urine				
			Thyroid trouble				Sugar or albumin in urine				
			Tuberculosis				VD—Syphilis, gonorrhea, etc.				
			Asthma				Recent gain or loss of weight				
			Shortness of breath				Arthritis, Rheumatism, or Bursitis				
			Pain or pressure in chest				Bone, joint or other deformity				
			Chronic cough				Lameness				
			Palpitation or pounding heart				Loss of finger or toe	12. FEMALES ONLY: HAVE YOU EVER			
			Heart trouble				Painful or "trick" shoulder or elbow				Been treated for a female disorder
			High or low blood pressure				Recurrent back pain				Had a change in menstrual pattern

13. WHAT IS YOUR USUAL OCCUPATION?

14. ARE YOU (Check one)
☐ Right handed ☐ Left handed

93–101

Sample 6. SF-93: Report of medical history.

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT	
		15. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.	
		B. Inability to perform certain motions.	
		C. Inability to assume certain positions.	
		D. Other medical reasons (*If yes, give reasons.*)	
		16. Have you ever been treated for a mental condition? (*If yes, specify when, where, and give details.*)	
		17. Have you ever been denied life insurance? (*If yes, state reason and give details.*)	
		18. Have you had, or have you been advised to have, any operations? (*If yes, describe and give age at which occurred.*)	
		19. Have you ever been a patient in any type of hospitals? (*If yes, specify when, where, why, and name of doctor and complete address of hospital.*)	
		20. Have you ever had any illness or injury other than those already noted? (*If yes, specify when, where, and give details.*)	
		21. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (*If yes, give complete address of doctor, hospital, clinic, and details.*)	
		22. Have you ever been rejected for military service because of physical, mental, or other reasons? (*If yes, give date and reason for rejection.*)	
		23. Have you ever been discharged from military service because of physical, mental, or other reasons? (*If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.*)	
		24. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? (*If yes, specify what kind, granted by whom, and what amount, when, why.*)	

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge.
I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."
25. Physician's summary and elaboration of all pertinent data (*Physician shall comment on all positive answers in Items 9 through 24. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.*)

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS

REVERSE OF STANDARD FORM 93

* GPO : 1971 O - 419-371

Sample 6. SF-93, cont'd.

☆ U. S. GOVERNMENT PRINTING OFFICE: 1970-979-303- 111

NAME (*Print or type—Last, First, Middle Initial*)	IDENTIFICATION NO.	
ORGANIZATIONAL UNIT	FROM (*Mo., Day, Hr.*) a.m. p.m.	NO. OF HOURS
TYPE OF LEAVE ☐ ANNUAL—"I understand that any annual leave authorized in excess of the amount available to me during the leave year will be charged to LWOP." ☐ SICK—Complete other side of this form. ☐ WITHOUT PAY ☐ COMPENSATORY ☐ OTHER (*Specify*)	TO (*Mo., Day, Hr.*) a.m. p.m.	
REMARKS	SIGNATURE OF EMPLOYEE	DATE

INSTRUCTIONS: Complete above part of form. If applying for sick leave, check appropriate box on back (top) of form. If you were under care of a doctor, he should complete "CERTIFICATE OF PHYSICIAN OR PRACTITIONER" also on back.

OFFICIAL ACTION ON APPLICATION

☐ APPROVED ☐ DISAPPROVED (*If disapproved, give reason*)	SIGNATURE AND DATE

STANDARD FORM 71 Revised November 1966 — 71-108 — **APPLICATION FOR LEAVE** — S/N-0108-200-5803 — U.S. CIVIL SERVICE COMMISSION FPM SUPPL. 990-2

(a)

EMPLOYEE (*If applying for sick leave*)	DURING THIS ABSENCE I WAS:	INCAPACITATED FOR DUTY BY: ☐ SICKNESS ☐ ON-THE-JOB INJURY ☐ OFF-THE-JOB INJURY ☐ PREGNANCY AND CONFINEMENT	☐ UNDERGOING MEDICAL, DENTAL, OR OPTICAL EXAMINATION OR TREATMENT
	☐ REQUIRED TO CARE FOR A MEMBER OF MY FAMILY WITH A CONTAGIOUS DISEASE (*Give name and relationship of member of family, and name of disease*)	☐ REQUIRED TO BE ABSENT BECAUSE OF EXPOSURE TO CONTAGIOUS DISEASE (*Give name of disease and circumstances of exposure*)	

CERTIFICATE OF PHYSICIAN OR PRACTITIONER

NAME OF EMPLOYEE	PERIOD UNDER PROFESSIONAL CARE	FROM (*Mo., Day, Year*)
POSITION OCCUPIED		TO (*Mo., Day, Year*)
REMARKS		

THE EMPLOYEE NAMED WAS UNDER MY PROFESSIONAL CARE DURING THE PERIOD STATED ABOVE. From the medical standpoint, his condition during this period was such that I considered it inadvisable for him to report to work.

SIGNATURE _____ DATE _____

(b)

Sample 7. SF 71-109: Application for leave. (a) Front (b) Reverse.

Standard Form 2801-B
U.S. Civil Service Commission
JANUARY 1966
FPM Supplement 831-1

PHYSICIAN'S STATEMENT

IN CONNECTION WITH DISABILITY RETIREMENT
CIVIL SERVICE RETIREMENT SYSTEM

PART A.—TO BE COMPLETED BY APPLICANT

INSTRUCTIONS

1. Complete Part A and give this form to your physician. He should complete Part B and mail it to the address you furnish in Item 4, Part A.
2. Neither your employing office nor the Civil Service Commission can pay any expense incurred in completing this form.

1. PRINT OR TYPE FULL NAME *(Last, First, Middle)*	2. DATE OF BIRTH *(Month, Day, Year)*

3. I HEREBY GIVE MY PERMISSION FOR YOUR RELEASE TO THE U.S. CIVIL SERVICE COMMISSION DIRECTLY OR THROUGH MY EMPLOYING OFFICE OF ANY OR ALL INFORMATION OR RECORDS CONNECTED WITH MY ILLNESS.

SIGNATURE	ADDRESS *(Including ZIP Code)*	DATE

4. IN SPACE BELOW, ENTER THE EXACT NAME AND ADDRESS (INCLUDING ZIP CODE) OF YOUR EMPLOYING OFFICE.

ADDRESS TO WHICH PHYSICIAN SENDS STATEMENT ➡

5. TITLE OF FEDERAL (OR D.C.) GOVERNMENT POSITION OCCUPIED. *(Explain duties to your personal physician.)*	6. IF YOU ARE PRESENTLY EMPLOYED IN ANY JOB OTHER THAN YOUR FEDERAL (OR D.C.) GOVERNMENT POSITION, PRINT OR TYPE BELOW DETAILS CONCERNING JOB, INCLUDING TYPE OF WORK PERFORMED.

PART B.—TO BE COMPLETED BY PHYSICIAN

INSTRUCTIONS

1. Report in detail the clinical symptoms and findings upon which your diagnosis and conclusions are based. A complete and objective report may permit a decision on the claim for disability without need for further examination and inconvenience to the applicant.
2. The applicant is responsible for any costs incurred in connection with your statement.
3. Send the completed form to the office named by the applicant in Item 4, Part A.
4. You may enclose this report in a sealed envelope marked "Disability Retirement-Privileged-Private."

MEDICAL HISTORY

1. HOW LONG HAS EMPLOYEE BEEN UNDER YOUR PROFESSIONAL CARE FOR THE INDICATED DISABILITY? *(Give dates)*	2. WHEN DID YOU LAST SEE THE EMPLOYEE FOR EXAMINATION OR TREATMENT? *(Give Dates)*

3. IF EMPLOYEE IS CURRENTLY HOSPITALIZED OR HAS BEEN HOSPITALIZED RECENTLY, PLEASE FURNISH:

NAME AND ADDRESS (INCLUDING ZIP CODE) OF HOSPITAL OR OTHER MEDICAL FACILITY	DATE OF ADMISSION	DATE OF DISCHARGE
	PLEASE ATTACH SUMMARY REPORT OF HOSPITALIZATION OR ABSTRACT OF HOSPITAL RECORDS.	

4. DESCRIBE FULLY THE ONSET OF DISABILITY, PROGRESSION, AND CURRENT SYMPTOMS

2801-303

PHYSICIAN: PLEASE COMPLETE OTHER SIDE OF THIS STATEMENT ALSO

Sample 8. SF 2801-B: Physician's statement in connection with disability retirement.

PHYSICAL FINDINGS

Describe the clinical findings in detail as fully as possible, particularly with respect to the condition which is considered disabling. Your complete and objective report of medical examination is of the utmost importance to the Government and to the applicant for disability retirement.

1. HEIGHT	2. WEIGHT	3. TEMPERATURE	4. MUSCULAR DEVELOPMENT	5. PULSE	6. RESPIRATION

7. NUTRITION	8. POSTURE	9. GAIT	10. GENERAL APPEARANCE	11. BLOOD PRESSURE
				SYSTOLIC _____ DIASTOLIC _____

12. COMPLETE PHYSICAL FINDINGS

(IF ADDITIONAL SPACE IS REQUIRED, PLEASE CONTINUE ON SEPARATE SHEET)

DIAGNOSIS

CONCLUSIONS

NOTE: Under the civil service retirement system, the term disability means disabled for useful and efficient service in the grade or class of position last occupied by the employee, by reason of disease or injury not due to vicious habits, intemperance, or willful misconduct.

1. IS EMPLOYEE DISABLED FOR THE POSITION NAMED IN PART A, ITEM 5?	2. DATE DISABILITY BEGAN?	3. HOW LONG IS DISABILITY EXPECTED TO LAST?	4. IS DISABILITY DUE TO VICIOUS HABITS, INTEMPERANCE OR WILLFUL MISCONDUCT?
☐ YES ☐ NO			☐ YES ☐ NO

PHYSICIAN'S NAME AND ADDRESS

1. TYPE OR PRINT PHYSICIAN'S NAME	2. PHYSICIAN'S SIGNATURE
3. PHYSICIAN'S ADDRESS (INCLUDING ZIP CODE)	4. DATE

Sample 8. SF 2801-B, cont'd.

UNITED STATES CIVIL SERVICE COMMISSION

FORM APPROVED
BUDGET BUREAU NO. 50-R342

EYE EXAMINATION

1. NAME (LAST) (FIRST) (MIDDLE)	2. DATE OF BIRTH	3. SEX ☐ MALE ☐ FEMALE
4. ADDRESS (NUMBER, STREET, CITY, STATE AND ZIP CODE)	5. POSITION TITLE	

TO EXAMINER: This examination is necessary in order to evaluate the individual's visual ability to efficiently perform the duties of the position shown above without hazard to himself and others. (If additional space is required to answer any question(s), attach separate sheet.)

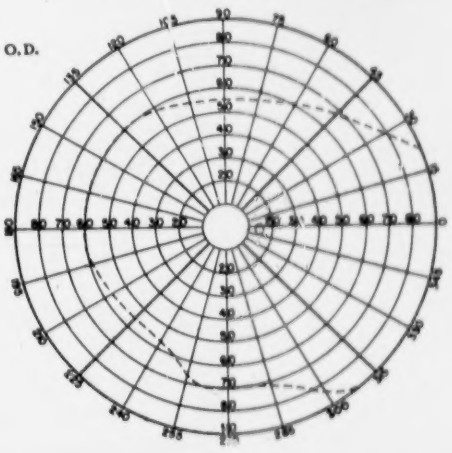
6. CENTRAL VISUAL ACUITY—Snellen test letters should be used for testing distant vision and Jaeger test letters for near vision.

	DISTANCE - (SNELLEN READING)			NEAR - (JAEGER READING)		
	WITHOUT CORRECTION	WITH CORRECTION	BEST CORRECTION POSSIBLE	WITHOUT CORRECTION	WITH CORRECTION	BEST CORRECTION POSSIBLE
O.D.						
O.S.						

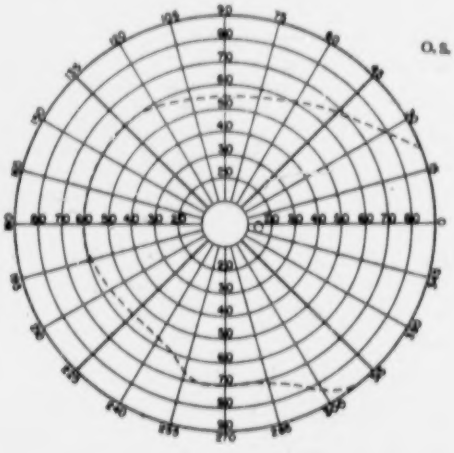
7. FIELD VISION—The visual field shall be determined on a standard perimeter using a white test object which subtends one degree. This test object shall measure 0.228 inch (5.8 mm.) and a standard perimeter shall have a radius of 12.9 inches (330 mm.). Is there any loss of field vision? . . . . . ☐ YES ☐ NO

INDICATE FIELD VISION ON THE VISUAL FIELD CHARTS.

O.D.



O.S.



8. FUNDI AND MEDIA—Are there any abnormalities in the following: cornea, lens, aqueous and vitreous humor optic disc; blood vessels; retina and choroid? . . . . . ☐ YES ☐ NO
If answer is "YES," indicate which and explain below.

9. OTHER CONSIDERATIONS—Examine for disturbances of accommodation, color vision, adaptation to light and dark, metamorphosia, entropion, ectropion, conjunctivitis, blepharitis, pterygium, dacryocystitis, dacryadenitis, trachoma, keratitis, keratoconus, corneal scars, uveitis, iritis, cyclitis, iridocyclitis, cataract, and certain muscle disturbances not included under diplopia. Are any of the above-mentioned disabilities present? . . . . . ☐ YES ☐ NO
If answer is "YES," explain fully below.

(OVER)

CSC FORM 740

Sample 9. CSC Form 740: Eye examination.

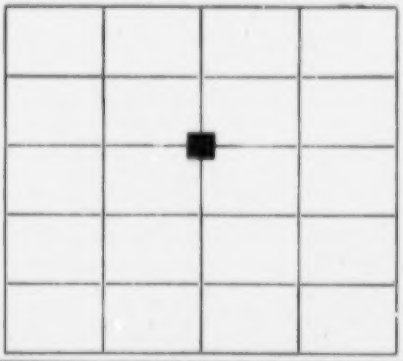
10A. Has the lens of either eye been removed? . . . . . ☐ YES ☐ NO

10B. Is there any evidence of increased ocular tension or glaucoma? . . . . . ☐ YES ☐ NO
If the lens of either eye has been removed or if there is any evidence of increased ocular tension, report the tenonometer readings. . . . . _____

11. Is there any defect of the eyes which will have a tendency to be progressive? . . . . . ☐ YES ☐ NO
If answer is "YES," explain fully below.

_____

12. BINOCULAR VISION—Is diplopia present? . . . . . ☐ YES ☐ NO
When diplopia is present, this shall be plotted in the chart at right by placing an "X" in each rectangle (4 x 5 degrees in size) in which diplopia is found.



Treatment recommended--medical or other therapy

_____

_____

_____

_____

_____

_____

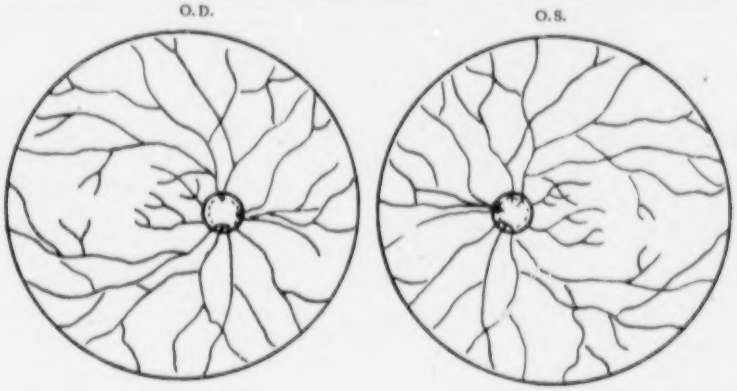
Are glasses recommended? _____

13. OTHER DEFECTS— Does patient to his or your knowledge have any other visual defects? . . . . . ☐ YES ☐ NO
If so, describe briefly.

_____

14. FUNDI

O.D. O.S.



15. REMARKS:

SIGNATURE OF EXAMINER	DATE
NAME OF EXAMINER *(TYPE OR PRINT)*	ADDRESS *(NUMBER, STREET, CITY, STATE, AND ZIP CODE)*

Sample 9. CSC Form 740, cont'd.

FORM APPROVED.
BUDGET BUREAU NO. 50-R337

UNITED STATES CIVIL SERVICE COMMISSION
BUREAU OF RETIREMENT AND INSURANCE
WASHINGTON 25, D. C.

MEDICAL REPORT (EPILEPSY)

1. MR. MRS. MISS (First name) (Middle initial) (Last name)	2. DATE OF BIRTH	3. ☐ MALE ☐ FEMALE
4. ADDRESS	5. TITLE OF POSITION	

6. TO THE EXAMINING PHYSICIAN:

The purpose of this report is to secure a thorough record of an individual who is being considered for employment in the Federal service, and for whom previous medical evidence discloses a history of epilepsy. The U.S. Civil Service Commission, in examining a person for a position in the Federal service, must determine the following:

(a) Is he (or she) physically capable of performing the duties of the position efficiently;

(b) Would employment be hazardous to himself (or herself) or to others?

Since it has been determined that a history of epilepsy exists, it becomes necessary to decide whether this individual's physical condition is such as to allow his employment. Considerable weight will be given to your findings in this case from the standpoint of the present status of the individual, prognosis, and recommendations as to employability.

Any fee in connection with rendering a report on this form is usually paid by the person under consideration. In any case where the fee is to be paid by the Government, this report form will be accompanied by an appropriate separate voucher form.

7. DATE OF ONSET OF SEIZURES:	8. TYPE: ☐ GRAND MAL ☐ PETIT MAL ☐ PSYCHOMOTOR ☐ JACKSONIAN

9. MEDICATION OR TREATMENT GIVEN:

10. PRIOR TO TREATMENT-- Frequency of seizures: Severity of seizures:	11. EFFECT OF TREATMENT ON-- Frequency of seizures: Severity of seizures:

12. DATE OF LAST SEIZURE:	13. ANY EVIDENCE OF MENTAL DETERIORATION? ☐ YES ☐ NO	14. IS THIS PERSON UNDER CONTINUING MEDICAL CARE? ☐ YES ☐ NO

15. WAS THE INDIVIDUAL HOSPITALIZED? ☐ YES ☐ NO If "Yes," please complete the information requested below:

(A) Name and address of hospital:	(B) Dates of hospitalization:

16. RECOMMENDATIO PHYSICIAN AS TO EMPLOYABILITY.

Do you recommend this individual for employment in the position shown in item 5 above. ☐ YES ☐ NO

Specify any general limitations as to work capacity relative to physical demands or environmental conditions:

17. DATE	18. TYPE OR PRINT NAME OF PHYSICIAN
19. SIGNATURE OF PHYSICIAN	20. ADDRESS OF PHYSICIAN (Street and Number, City and State)

21. PHYSICIAN'S TITLE (If connected with a hospital):

HOSPITAL:

LOCATION (City and State):

CSC FORM 739
FEBRUARY 1963

Sample 10. CSC Form 739: Medical report (Epilepsy).

UNITED STATES CIVIL SERVICE COMMISSION
WASHINGTON 25, D. C.

Form Approved
Budget Bureau No. 50-R276.1

MEDICAL REPORT
(Diabetes Mellitus)

1. NAME OF APPLICANT (Last) (First) (Middle)	2. DATE OF BIRTH (Mo., Day, Yr.)
3. ADDRESS (Street and Number) (City and State)	4. POSITION APPLIED FOR

5. THE POSITION APPLIED FOR REQUIRES
- ☐ a. Operation of a motor vehicle.
- ☐ b. Working around dangerous power-driven machinery.
- ☐ c. Working above ground or floor level.
- ☐ d. Working around open vats or pits.
- ☐ e. Other: _____

IMPORTANT

TO THE REPORTING PHYSICIAN: The purpose of this report is to determine if the above applicant for the position indicated is physically capable of performing the duties involved without hazard to himself or others. Any fee will be paid by the examinee.

6. HISTORY OF DIABETIC CONDITION
- a. Has applicant been under regular medical care? ☐ YES ☐ NO
- b. Age at onset: _____ years
- c. How soon after onset was treatment started? _____ years _____ months
- d. Any history of diabetic coma or complications? ☐ YES ☐ NO
  if "Yes," please describe:
- e. Any history of insulin reaction? ☐ YES ☐ NO
  if "Yes," give number and date of most recent occurrence:
- f. Kind of insulin and/or anti-diabetic medication used: _____ amount: _____
- g. Diet: C. _____ F. _____ P. _____
- h. Report of most recent blood sugar: ☐ Fasting ☐ Post Prandial Date: _____ Mgm % _____
- i. Indicate your opinion of applicant's control:
  ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Unknown
- j. Height: _____ feet _____ inches Weight: _____ pounds

7. USE THIS SPACE *(and reverse side, if necessary)* TO MAKE ANY ADDITIONAL REMARKS OR EXPLANATIONS CONCERNING YOUR ANSWERS TO ANY OF THE ABOVE ITEMS

8. DATE	9. SIGNATURE OF APPLICANT
10. SIGNATURE OF PHYSICIAN	11. ADDRESS OF PHYSICIAN *(Street and Number)* *(City and State)*

CSC FORM 3684
APRIL 1959

Sample 11. CSC Form 3684: Medical report (Diabetes mellitus).

UNITED STATES CIVIL SERVICE COMMISSION

FORM APPROVED
BUDGET BUREAU NO. 80-R196.3

MEDICAL REPORT (PULMONARY TUBERCULOSIS)

1. NAME OF APPLICANT (Last) (First) (Middle)	2. DATE OF BIRTH (Mo., Day, Yr.)
3. ADDRESS (Number and Street) (City, State and ZIP Code)	4. POSITION APPLIED FOR

5. **TO THE EXAMINING PHYSICIAN:** The purpose of this report is to secure a thorough record of an individual who is being considered for employment (or reemployment) in the Federal service, and in whose case available information indicates a history of pulmonary tuberculosis. The U. S. Civil Service Commission, in examining persons for positions in the Federal service, endeavors to secure those who are:

(a) Physically capable of performing the duties of the position efficiently.
(b) Free from defects or diseases which would constitute an employment hazard to themselves or to others.

Since available information indicates the existence of a history of pulmonary tuberculosis, it becomes necessary to decide whether this individual's physical condition is such as to allow his employment in the light of the objective mentioned above. Considerable weight will be given your findings in this case from the standpoint of the present status of the individual, prognosis, and recommendation as to employability. Your findings are subject to review by Federal medical officers, either of the U. S. Civil Service Commission or the employing agency.

Any fee in connection with rendering a report on this form is usually paid by the person under consideration. In any case where the fee is to be paid by the government, this report form will be accompanied by an appropriate separate voucher form.

6. DATE DISEASE WAS DIAGNOSED (Mo., Yr.)	7. WEIGHT AT TIME OF DIAGNOSIS pounds	8. WEIGHT ONE YEAR PRIOR TO LAST EXAMINATION pounds	9. WEIGHT AT LAST EXAMINATION pounds	10. HEIGHT AT LAST EXAMINATION ft. in.

11. WAS THE INDIVIDUAL HOSPITALIZED? ☐ YES ☐ NO If "Yes," please complete this item.

(A) DATE OF FIRST ADMISSION (Mo., Yr.)	(B) DATE OF DISCHARGE (Mo., Yr.)	(C) NAME AND ADDRESS (Including ZIP Code) OF HOSPITAL
(D) DATE OF LAST ADMISSION (Mo., Yr.)	**(E) DATE OF DISCHARGE (Mo., Yr.)**	**(F) NAME AND ADDRESS (Including ZIP Code) OF HOSPITAL**

12. PRESENT STATUS OF INDIVIDUAL	(A) DATE OF LAST EXAMINATION WHICH MUST BE WITHIN 6 MONTHS OF THE DATE OF THIS REPORT			(B) GENERAL PHYSICAL CONDITION ☐ GOOD ☐ FAIR ☐ POOR
(C) X-RAY FINDINGS ON LAST EXAM	☐ Cavity ☐ Yes ☐ No Number of Months:	☐ Lesions Progressive Number of Months:	☐ Lesions Stationary Number of Months:	☐ Lesions Retrogressive Number of Months:

(D) BACTERIOLOGICAL TEST FINDINGS		DATE OF LAST POSITIVE (Mo., Yr.)	NUMBER OF NEGATIVES SINCE LAST POSITIVE	DATE OF LAST NEGATIVE (Mo., Yr.)
DIRECT SMEAR				
CONCENTRATED SMEAR				
CULTURE	SPUTUM			
	GASTRIC			
GUINEA PIG	SPUTUM			
	GASTRIC			

13. CLINICAL CLASSIFICATION BASED ON NATIONAL TUBERCULOSIS ASSOCIATION STANDARDS OF 1961

(A) EXTENT OF DISEASE (Check appropriate box) ☐ Minimal ☐ Moderately Advanced ☐ Far Advanced

(B) PRESENT ACTIVITY STATUS (Check appropriate numbered box)

	(1) ☐ INACTIVE	(2) ☐ QUIESCENT	(3) ☐ ACTIVE
X-RAY FINDINGS	Stable, or very slow shrinkage of lesions. No roentgenological evidence of cavity.	Stable or improving. Cavitation may be present.	Progressive, retrogressive, or stationary lesion.
SYMPTOMS	None	Present or Absent	Present
BACTERIOLOGICAL TEST FINDINGS	Negative by repeated concentrated smear and culture or guinea pig.	Negative by repeated concentrated smear and culture, or guinea pig.	Usually Positive
TIME	Six Months	Six Months	
(4) ACTIVITY UNDETERMINED	☐ Probably Inactive	☐ Probably Quiescent	☐ Probably Active

(C) IF INDIVIDUAL IS RECEIVING CHEMOTHERAPY, SPECIFY DRUG(S) ADMINISTERED AND DATE BEGUN

(SEE REVERSE SIDE)

CSC FORM 4434
NOVEMBER 1966

Sample 12. CSC Form 4434: Medical report (Pulmonary tuberculosis).

13. CLINICAL CLASSIFICATION BASED ON NATIONAL TUBERCULOSIS ASSOCIATION STANDARDS OF 1981 *(Continued)*

(D) EXERCISE STATUS *(Check appropriate box and indicate number of months individual has been in that class):*

CLASSIFICATION	NUMBER OF MONTHS
☐ Class I. BED REST	
☐ Class II. SEMI-AMBULATORY (4 hr. total out of bed per day)	
☐ Class III. AMBULATORY	
☐ Class IV. LIVING UNDER ORDINARY CONDITIONS	

(E) HAVE ANY OF THE FOLLOWING TYPES OF THERAPY BEEN USED? ☐ YES ☐ NO If "Yes," indicate the type of therapy used by inserting in the appropriate box the dates during which that type of therapy was used.

TYPE OF THERAPY		PNEUMOTHORAX	PHRENIC CRUSH	PNEUMO-PERITONEUM	THOROCOPLASTY	RESECTION	PLUMBAGE
DATES USED	FROM						
	TO						

14. STATE TREATMENT YOU HAVE RECOMMENDED TO BE FOLLOWED AT THE PRESENT TIME.

15. JOB DESCRIPTION. *(Employing officer should furnish brief description of work to be performed, including physical demands and environmental conditions)*

16. RECOMMENDATION OF PHYSICIAN AS TO EMPLOYABILITY IN JOB DESCRIBED ABOVE.

Do you recommend this individual for employment in the job described above:

Full Time (8 hours)? ☐ Yes ☐ No

Part Time? ☐ Yes (Indicate number of hours: ____) ☐ No

Specify any general limitations as to work capacity of individual relative to physical demand or environmental conditions:

17. DATE	18. TYPE OR PRINT NAME OF PHYSICIAN
19. SIGNATURE OF PHYSICIAN	20. ADDRESS OF PHYSICIAN *(Number, Street, City, State and ZIP Code)*

21. PHYSICIAN'S TITLE *(If connected with a tuberculosis hospital):*

HOSPITAL:

LOCATION *(City, State and ZIP Code)*

Sample 12. CSC Form 4434, cont'd.

UNITED STATES CIVIL SERVICE COMMISSION

FILE:

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

NAME OF HOSPITAL OR PHYSICIAN	DATES OF HOSPITALIZATION OR TREATMENT	
	FROM	TO
STREET NUMBER		
CITY, STATE, AND ZIP CODE		

I hereby authorize release to the U.S. Civil Service Commission of any information in your records, including diagnosis, laboratory, x-rays, and all other examinations in connection with my hospitalization or illness.

YOUR NAME (TYPE OR PRINT)	SIGNATURE
STREET NUMBER	
CITY, STATE, AND ZIP CODE	DATE

CSC FORM 3986
NOVEMBER 1967

GPO 839-275

Sample 13. CSC Form 3986: Authorization for release of medical records.

Budget Bureau
Approved 50–R0390

REPORT OF MEDICAL HISTORY
U.S. Civil Service Employees and Applicants

This information is for official and medically-confidential use only and will not be released to unauthorized persons.

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. TITLE OF POSITION	3. SOCIAL SECURITY NUMBER
4. HOME ADDRESS *(Number, street or RFD, city or town, State, and ZIP Code)*	**5. PURPOSE OF EXAMINATION**	**6. DATE OF EXAMINATION**

7. SEX	8. TOTAL YEARS GOVERNMENT SERVICE		9. AGENCY	10. ORGANIZATION UNIT
	MILITARY	CIVILIAN		

11. DATE OF BIRTH	12. PLACE OF BIRTH	13. EXAMINING FACILITY OR EXAMINER, AND ADDRESS *(Including ZIP Code)*

14. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint exists)*

15. DO YOU *(Please check at left of each item):*

YES	NO	*(Check each item)*
		WEAR GLASSES OR CONTACT LENSES
		HAVE VISION IN BOTH EYES
		WEAR A HEARING AID
		STUTTER OR STAMMER HABITUALLY
		WEAR A BRACE OR BACK SUPPORT

16. HAVE YOU EVER *(Please check at left of each item):*

YES	NO	*(Check each item)*
		LIVED WITH ANYONE WHO HAD TUBERCULOSIS
		COUGHED UP BLOOD
		BLED EXCESSIVELY AFTER INJURY OR TOOTH EXTRACTION

17. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item):*

YES	NO	DON'T KNOW	*(Check each item)*	YES	NO	DON'T KNOW	*(Check each item)*	YES	NO	DON'T KNOW	*(Check each item)*
			SCARLET FEVER, ERYSIPELAS				ASTHMA				RECENT GAIN OR LOSS OF WEIGHT
			DIPHTHERIA				SHORTNESS OF BREATH				ARTHRITIS OR RHEUMATISM
			RHEUMATIC FEVER				PAIN OR PRESSURE IN CHEST				BONE, JOINT, OR OTHER DEFORMITY
			SWOLLEN OR PAINFUL JOINTS				CHRONIC COUGH				LAMENESS
			MUMPS				PALPITATION OR POUNDING HEART				LOSS OF ARM, LEG, FINGER, OR TOE
			COLOR BLINDNESS				HIGH OR LOW BLOOD PRESSURE				PAINFUL OR "TRICK" SHOULDER OR ELBOW
			FREQUENT OR SEVERE HEADACHE				CRAMPS IN YOUR LEGS				RECURRENT BACK PAIN
			DIZZINESS OR FAINTING SPELLS				FREQUENT INDIGESTION				"TRICK" OR LOCKED KNEE
			EYE TROUBLE				STOMACH, LIVER, OR INTESTINAL TROUBLE				FOOT TROUBLE
			EAR, NOSE, OR THROAT TROUBLE				GALL BLADDER TROUBLE OR GALLSTONES				HERNIA
			RUNNING EARS				JAUNDICE				PARALYSIS *(Inc. infantile)*
			HEARING LOSS				ANY ADVERSE REACTION TO SERUM, DRUG, OR MEDICINE				EPILEPSY OR FITS
			CHRONIC OR FREQUENT COLDS				BROKEN BONES				CAR, TRAIN, SEA, OR AIR SICKNESS
			SEVERE TOOTH OR GUM TROUBLE				TUMOR, GROWTH, CYST, OR CANCER				FREQUENT TROUBLE SLEEPING
			SINUSITIS				RUPTURE/HERNIA				FREQUENT OR TERRIFYING NIGHTMARES
			HAY FEVER				APPENDICITIS				DEPRESSION OR EXCESSIVE WORRY
			HEAD INJURY				PILES OR RECTAL DISEASE				LOSS OF MEMORY OR AMNESIA
			SKIN DISEASES				FREQUENT OR PAINFUL URINATION				NERVOUS TROUBLE OF ANY SORT
			GOITER				KIDNEY STONE OR BLOOD IN URINE				ANY DRUG OR NARCOTIC HABIT
			TUBERCULOSIS				SUGAR OR ALBUMIN IN URINE				EXCESSIVE DRINKING HABIT
			SOAKING SWEATS *(Night sweats)*				BOILS				PERIODS OF UNCONSCIOUSNESS

18. HOW MANY JOBS HAVE YOU HAD IN THE PAST THREE YEARS?	19. WHAT IS THE LONGEST PERIOD YOU HELD ANY OF THESE JOBS? MONTHS	20. WHAT IS YOUR USUAL OCCUPATION?	21. ARE YOU *(Check one)* ☐ RIGHT HANDED ☐ LEFT HANDED

OPTIONAL FORM 58
MAY 1968
U.S. CIVIL SERVICE COMMISSION
FPM CHAPTER 293
5058-101

Sample 14. Optional Form 58: Report of medical history.

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED "YES" MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT
		22 HAVE YOU BEEN REFUSED EMPLOYMENT OR BEEN UNABLE TO HOLD A JOB BECAUSE OF A SENSITIVITY TO CHEMICALS, DUST, SUNLIGHT, ETC.
		B INABILITY TO PERFORM CERTAIN MOTIONS
		C INABILITY TO ASSUME CERTAIN POSITIONS
		D OTHER MEDICAL REASONS *(If yes, give reasons)*
		23 HAVE YOU EVER WORKED WITH RADIOACTIVE SUBSTANCE?
		24 HAVE YOU EVER BEEN DENIED LIFE INSURANCE? *(If yes, state reason and give details)*
		25 HAVE YOU HAD, OR HAVE YOU BEEN ADVISED TO HAVE ANY OPERATIONS? *(If yes, describe and give age at which occurred)*
		26 HAVE YOU EVER BEEN A PATIENT IN ANY TYPE OF HOSPITAL? *(If yes, specify when, where, why, and name of doctor and complete address of hospital)*
		27 HAVE YOU EVER HAD ANY ILLNESS OR INJURY OTHER THAN THOSE ALREADY NOTED? *(If yes, specify when, where, and give details)*
		28 HAVE YOU CONSULTED OR BEEN TREATED BY CLINICS, PHYSICIANS, HEALERS, OR OTHER PRACTITIONERS WITHIN THE PAST 5 YEARS FOR OTHER THAN MINOR ILLNESSES? *(If yes, give complete address of doctor, hospital, clinic, and details)*
		29 HAVE YOU EVER BEEN REJECTED FOR MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? *(If yes, give date and reason for rejection)*
		30 HAVE YOU EVER BEEN DISCHARGED FROM MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? *(If yes, give date, reason, and type of discharge - whether honorable, other than honorable, for unfitness or unsuitability)*
		31 HAVE YOU EVER RECEIVED, IS THERE PENDING, OR HAVE YOU APPLIED FOR PENSION OR COMPENSATION FOR EXISTING DISABILITY? *(If yes, specify what kind, granted by whom, and what amount, when, why)*

I CERTIFY THAT I HAVE REVIEWED THE FOREGOING INFORMATION SUPPLIED BY ME AND THAT IT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE

I AUTHORIZE ANY OF THE DOCTORS, HOSPITALS, OR CLINICS MENTIONED ABOVE TO FURNISH THE GOVERNMENT A COMPLETE TRANSCRIPT OF MY MEDICAL RECORD FOR PURPOSES OF PROCESSING MY APPLICATION FOR THIS EMPLOYMENT OR SERVICE

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED HAVE ENVELOPE TO BE OPENED BY MEDICAL OFFICER ONLY

32 PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Physician shall comment on all positive answers in items 15 through 31. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS

☆ U.S. GOVERNMENT PRINTING OFFICE: 1969 O—307-384

Sample 14. Optional Form 58, cont'd.

DISPENSARY PERMIT
NAVSO 5100/9 (REV. 9/67) (FACE)
S/N--0104--904--0301 CASE NO.

TO DISPENSARY (Location)		DATE
EMPLOYEE'S NAME		SOCIAL SECURITY NO.
RATING	TIME LEFT JOB	TIME RETURNED
RETURN TO SUPERVISOR (Name)		SHOP
REASON FOR REFERRAL		
MEDICAL OFFICER'S REPORT	TIME REPORTED	TIME RELEASED
OCCUPATIONAL ☐ YES ☐ NO ☐ QUES-TIONABLE	OTHER	
DISPOSITION ☐ RW ☐ LD ☐ LT ☐ SH	RETURN FOR FURTHER TREATMENT	
REMARKS		

SIGNATURE

M.C., U.S.N.

(a)

DATE TO REPORT FOR RE-TREATMENT	TIME			
	SUPERVISOR	DISPENSARY		SUPERVISOR
	LEFT WORK	ARRIVED	LEFT	RETURNED TO WORK

DISCHARGED, TREATMENT TERMINATED	DATE	HOUR

SIGNED BY

MEDICAL OFFICER.

SUPERVISOR IS TO RETURN THIS REPORT TO SAFETY OFFICE IMMEDIATELY UPON TERMINATION OF TREATMENTS.	RECEIVED BY
	SAFETY OFFICER.

NAVSO 5100/9 (Rev. 9-67) (BACK) ☆ GPO

(b)

Sample 15. NAVSO 5100/9: Dispensary permit. (a) Front (b) Back.

CARDIAC FOLLOWUP SHEET

Date _____

NAME: _____ YEAR OF BIRTH: _____

TITLE OR POSITION _____ DEPARTMENT: _____

HISTORY: _____

_____

DIAGNOSIS: _____

FUNCTIONAL: _____ THERAPEUTIC: _____

BP: _____ P: _____ WEIGHT: _____

MEDICATION: _____

FREQUENCY OF MEDICAL SUPERVISION: _____

FOLLOWUP VISITS

DATE			
BP			
WEIGHT			
PULSE RHYTHM			
EDEMA			
MEDICATIONS			
SYMPTOMS			
DATE OF LAST MEDICAL VISIT			
RECOMMENDATIONS			
RETURN (MOS.)			

Sample 16. Cardiac followup sheet.

DIABETIC FOLLOWUP SHEET

Date: _____

NAME: _____ YEAR OF BIRTH: _____

TITLE OR POSITION: _____ DEPARTMENT: _____

DATE SHEET STARTED: _____ DIABETIC FOR ____ YEARS

WEIGHT AT ONSET: _____ HEIGHT: _____ BP AT ONSET: _____

TODAY: _____ TODAY: _____

ORIGINAL TREATMENT: _____

LAB RESULTS TODAY: _____ HOME URINE CHECKS ☐ YES ☐ NO

FREQUENCY OF MEDICAL SUPERVISION: _____

ANY HISTORY OF DIABETIC COMA OR COMPLICATIONS? (DESCRIBE): _____

_____

SEVERITY: ☐ MILD ☐ MODERATE ☐ OTHER: _____

CONTROL: ☐ FAIR ☐ GOOD ☐ EXCELLENT

RECOMMENDATIONS: _____

FOLLOWUP VISITS

DATE			
BP			
LABORATORY			
DATE OF LAST VISIT TO PHYSICIAN			
MEDICATION AND DIET			
RECOMMENDATIONS			
RETURN (MOS.)			

Sample 17. Diabetic followup sheet.

HEALTH EVALUATION PROCEDURES

NAME _____ YEAR OF BIRTH _____ SEX __

OCCUPATION _____

	Interval	
	6 months	12 months
Interval history		
General physical		
Special Exams		
Skin		
Neurological		
Nasal		
Special Procedures:		
Audiogram		
Vision		
Vital capacity		
Blood pressure		
Weight		
Laboratory:		
Hematology:		
Hematocrit		
White count		
Differential		
Sedimentation rate		
Chemistry:		
Blood sugar		
Cholinesterase		
Icteric Index		
Transaminase		
Other:		
Urinalysis:		
Routine		
Porphyrins		
Sulfates		
Trichloroacetic acid		
X-ray		
Chest		
Other:		
Electrocardiogram:		

Sample 18. Health evaluation procedures.

HUMANITARIAN EMERGENCY CARE

Date: _____

Statement of _____
(Full Name) (Status)

_____
(Address) Age

_____
(Name and address of parent, contractor, or firm)

Injury incurred at _____ _____ _____
(Time) (Date) (Location)

Brief statement of circumstances:

_____
(Name and address of insurance company if a contractor employee)

STATEMENT

"This is to certify that, to the best of my knowledge, I have received proper and adequate emergency treatment or first aid for the injury noted below. Further, I relieve the United States Government of any liability in connection with this injury, as it was incurred through no negligence on the part of the U.S. Naval Ammunition Depot, Crane, Indiana, or its employees."

_____ _____
(Witness) (Signature)

Diagnosis:

Treatment:

Disposition:

Sample 19. Humanitarian emergency care record.

DEPARTMENT OF THE NAVY

Re: _____
_____
_____

EDC:

Dear Physician:

The above named employee of this activity states that she is receiving prenatal care from you.

It is the policy of the Medical Department to permit women to continue at their regular work so long as the pregnancy is proceeding normally. Ordinarily the employee should cease work not later than six weeks before the anticipated date of delivery.

Because of the nature of some of the positions at the depot, it is advisable to observe such employees closely to ascertain that they remain able to work without endangering their pregnancy, and without hazard to themselves or others.

If the expected date of confinement is not correct, or should any complication or condition develop during the course of her gestation which would warrant restriction of her activities or even discontinuing her work, please advise us.

We wish to cooperate to the fullest extent possible for the welfare of your patient.

Yours truly,

_____, M.D.

Sample 20. Letter to physician for confirmation of pregnancy and advisability of continuing work.

MEDICAL FOLLOWUP CARD

NAME _____ PAY NO _____

DEPT _____

CONDITION _____

DATE RETURN VISIT TESTS

(Blue cards for Diabetics, Green cards for Cardiacs, White for other)

Sample 21. Medical followup card.

OCCUPATIONAL INJURY AND ILLNESS REPORT

(NOT MEDICALLY CONFIDENTIAL)

Patient's name	Pay No.	Bldg.	Dept.	Supervisor & Phone	Date

Patient's description of how, when and where illness occurred

Signature of Nurse or Attendant

Physician's impression of cause, extent, and relation to employment

Was the cause of the injury or illness occupational? ☐ Yes ☐ No ☐ Questionable
Should the case be referred to the Industrial Hygienist? ☐ Yes ☐ No

Physician's signature date

Industrial Hygienist's report

Signature of Industrial Hygienist date

Final decision

☐ Occupational ☐ Non-occupational

Signature of Physician date

Sample 22. Occupational injury or illness report.

PHYSIOTHERAPY PRESCRIPTION AND RECORD

Patient _____ Area to treat _____

MODE OF TREATMENT	INTENSITY	DURATION
☐ Diathermy	_____	_____
☐ Ultrasonic	_____	_____
☐ Hydrotherapy	_____	_____
☐ Other:	_____	_____

Other Instructions: _____

Recheck by Physician: _____

DATES OF TREATMENT	COMPLETED (initials):
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signed _____ M.D.

Sample 23. Physiotherapy prescription and record.

DEPARTMENT OF THE NAVY

_____
_____
_____

To the Physician:

This patient is referred for care under Bureau of Employees' Compensation rules.

If, in your judgment, it is necessary or advisable that he not return to work by the following normal work day after being seen by you, please provide the Occupational Health Clinic with the following information:

(1) Extent of injury

(2) Approximate length of time he will be off work

(3) When he is to see you again

For your information, it is usually possible to provide some sort of light duty within any limitations you may recommend. If such limitations are required in any case, specify as completely as possible, including probable duration, then instruct patient to report back to the dispensary upon return.

Yours truly,

_____, M.D.

Phone _____

Sample 24. Request for information from physician.

DEPARTMENT OF THE NAVY

Re: _____

Dear Dr. _____ :

The above-named employee has returned from sick leave, stating that he was under your care for a heart attack.

Please complete the information requested below in order that we may return him to suitable activity.

SEVERITY	ALLOWABLE WORK	MEDICATION
☐ Questionable	☐ Light	☐ Vasodilator
☐ Mild	☐ Moderate	☐ Anticoagulants
☐ Moderate	☐ Regular	☐ Digitalis
☐ Severe		☐ Other: _____

Date of his next appointment with you _____

Sincerely yours,

_____ , M.D.

_____

REMARKS:

Sample 25. Request for information on employee following recovery from heart attack.

DEPARTMENT OF THE NAVY

Re: _____

Dear Doctor:

We have noted your request that the above named patient be allowed to return to "light duty" following his treatment for a non-occupational condition.

We have therefore requested his supervisor to limit his activity according to our best judgment, for a period of ten days. So far as possible we will cooperate and if you feel further restrictions are desirable, please advise us of the specific activities to be avoided and the length of time for such restrictions.

Yours truly,

_____, M.D.

Sample 26. Request for information on employee returning to light duty.

PART FIVE

REFERENCES

Selected References, 125

Reference List of Official Publications, 127

FPM Selected Chapter Listings, 129

FPM Chapter 792, 133

FPM-792 Letters and Attachments, 140

National Organizations Concerned with Occupational Health, 187

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1. ***Federal Personnel Manual*** **(FPM) Chapters**

   FPM 294 – Availability of Official Information

   FPM 339 – Qualification Requirements (Medical)

   FPM 792 – Federal Employees Occupational Health Program (see p. 133)

   FPM 810 – Injury Compensation

   FPM 831 – Retirement

   FPM Supplement 831-1 – Retirement

   Note: See also FPM Chapter 792 (p. 133), FPM 792 Letter and Attachments (p. 140), and FPM Selected Chapter Listings (p. 129)

2. **OFEC (Office of Federal Employees' Compensation) Publications**

   Pam BEC-136 – *Federal Employees' Compensation Act Basic Forms* (see p. 79)

   Regulations Governing Administration of Federal Employees' Compensation Act

3. **Navy Civilian Personnel Instructions (NCPI)**

   NCPI 352.4-7 – Disability Separation of Person with Defect Who Refuses to Secure Treatment or Take Leave

   NCPI 792 – Industrial Health Program

   NCPI 5100 – Safety (See also OPNAVINST 5100 series.)

4. ***Manual of the Medical Department*** **(MANMED), U.S. Navy**

   Chap. 1-2 – Chief, Bureau of Medicine and Surgery

   Chap. 15-30 – Diving Duty

   Chap. 15-57 – Civil Employees

   Chap. 15-69 – Standards for Class 2 Personnel (Aviation)

   Chap. 15-90 – Roentgenographic Examination of the Chest

   Chap. 22-6 – Industrial Hygiene

   Chap. 23 – Reports, Records and Forms

   Chap. 26 – Health Program Civil Service Employees

5. **Other Navy Instructions and Publications**

BUMEDINST 6150.19 Series – Civil Service Employee's Medical Record Jacket – Standardization

BUMEDINST 6200.7 Series – Heat Casualties, Prevention of

BUMEDINST 6260.6 Series – Hearing Conservation Program

BUMEDINST 6260.7 Series – Report of Occupational Health Services (MED-6260-1)

BUMEDINST 6260.10 Series – Eye Examination of Certain Designated Personnel Assigned Duty Involving Exposure to Ionizing and Non-ionizing Radiation

BUMEDINST 6260.12 Series – Chlorinated Hydrocarbons

NAVFACINST 11240.82 Series – Policy and Procedures for Testing and Licensing of Motor Vehicle Operators

NAVFAC P-80 – *Facility Planning Factors for Naval Shore Activities*

NAVFAC P-300 – *Motor Vehicle Operator Testing*

NAVMED P-5004 – *Handbook of the Hospital Corps*

NAVMED P-5010 – *Manual of Naval Preventive Medicine*

NAVMED P-5052 – *Technical Information for Medical Corps Officers*

NAVMED P-5055 – *Radiation Health Protection Manual*

NAVMED P-5112 – *Industrial Environmental Health Bulletins*

NAVSHIPSNOTE 5100.26 Series – Asbestos Exposure Hazards

OPNAVINST 5100 Series – Navy Safety Program

OPNAVINST 5100.14 Series – Sight Conservation Program

FEDERAL PERSONNEL MANUAL

(Selected Chapter Listings)

Following is a listing of individual chapters from the *Federal Personnel Manual* (FPM) which contains useful information. They are identified by chapter number and title.

Chapter No.	Subject Title
002	Table of Contents
003	Index
171	The Civil Service Commission Issuance System
210	Basic Concepts and Definitions (General)
211	Veteran Preference
212	Competetive Service and Competetive Status
213	Excepted Service
230	Organization of the Government for Personnel Management
250	Personnel Management in Agencies
251	Intramanagement Communications and Consultation
271	Developing Policies, Procedures, Programs and Standards
273	Inspections, Surveys and Audits
274	Corrective Actions
290	Personnel Information (General)
291	Personnel Reports
292	Personnel Data Standardization
293	Personnel Records and Files
294	Availability of Official Information
295	Personnel Forms and Documents
296	Processing Personnel Actions and Data
300	Employment (General)

Chapter No.	Subject Title
301	Overseas Employment
302	Employment in the Excepted Service
304	Employment of Experts and Consultants
305	Employment Under the Executive Assignment System
306	Selective Placement Programs
307	Transitional Appointments
310	Employment of Relatives
311	The Power of Appointment and Removal
312	Position Management
315	Career and Career-Conditional Employment
316	Temporary and Indefinite Employment
330	Recruitment, Selection and Placement
331	Organization for Recruitment and Examining
332	Recruitment and Selection through Competetive Examination
333	Recruitment and Selection for Temporary and Term Appointment Outside the Register
335	Promotion and Internal Placement
337	Examining System
338	Qualification Requirements (General)
339	Qualification Requirements (Medical)
351	Reduction in Force
352	Reemployment Rights
353	Restoration After Military Duty
410	Training
412	Executive Development
430	Performance Evaluation
451	Incentive Awards
511	Classification Under the General Schedule

Chapter No.	Subject Title
530	Pay Rates and Systems (General)
531	Pay Under the General Schedule
532	Coordinated Federal Wage System
534	Pay Under Other Systems
539	Conversion Between Pay Systems
550	Pay Administration (General)
571	Travel and Transportation for Recruitment
591	Allowances and Differentials Payable in Nonforeign Areas
594	Uniform Allowances
610	Hours of Duty
630	Absence and Leave
711	Employee-Management Cooperation
713	Equal Opportunity Employment
715	Voluntary Separations and Reductions in Rank or Pay
731	Suitability
732	Personnel Security Program
733	Political Activities of Federal Employees and Enrollees of the Job Corps
735	Employee Responsibilities and Conduct
736	Investigations
751	Discipline
752	Adverse Action by Agencies
754	Adverse Action by Commission
771	Employee Grievances and Administrative Appeals
772	Appeals to the Commission
790	Service to Employees (General)
810	Injury Compensation
831	Retirement

Chapter No.	Subject Title
832	Old Age, Survivors and Disability Insurance
850	Unemployment Benefits
870	Life Insurance
890	Federal Employee Health Benefits
910	Mobilization Readiness
930	Programs for Specific Positions and Examinations (Miscellaneous)
933	Qualification Requirements for Specific Positions

Chapter 792

Federal Employees Occupational Health Program

Contents

SUBCHAPTER 1. GENERAL PROVISIONS
1-1. Authority
1-2. Policy
1-3. Scope

SUBCHAPTER 2. AGENCY RESPONSIBILITIES
2-1. Role of the Civil Service Commission
2-2. Role of the Department of Health, Education, and Welfare
2-3. Role of the Department of Labor
2-4. Role of the General Services Administration
2-5. Role of Heads of Agencies

SUBCHAPTER 3. PROGRAM IMPLEMENTATION
3-1. Relationship to Management
3-2. Management Responsibilities
3-3. Management Understanding of Occupational Health

SUBCHAPTER 4. BASIC CONCEPTS OF OCCUPATIONAL HEALTH
4-1. General
4-2. Management Benefits
4-3. Program Objectives
4-4. Activities To Reach Objectives

Subchapter 1. General Provisions

1–1. AUTHORITY

a. Section 7901 of title 5 of the United States Code is the basic legal authority for providing occupational health services to Federal employees (see FPM SUPPLEMENT 990–1). In addition, Bureau of the Budget Circular A–72 establishes criteria to be followed by the heads of executive agencies in providing programs of health services under the basic law, and in relating them to programs established under the Federal Employees' Compensation Act to provide medical and other services and to eliminate health risks.

b. Under these authorities the head of each agency is required to review existing programs and is authorized and encouraged to establish an occupational health program to deal constructively with the health of the employees of his agency in relation to their work.

1–2. POLICY

While health maintenance is primarily the responsibility of the individual employee, the Federal employer has an obligation to provide a safe work environment for his employees. He also has a valid interest in preventing loss of work time and work efficiency resulting from his employees' ill health. Occupational health is, therefore, an integral part of progressive personnel management. FPM chapter 250 identifies the maintenance of an adequate employee occupational health program as an action the manager, together with the guidance and assistance of the personnel officer, should take in carrying out his responsibilities for manpower utilization. Good manpower utilization involves effectively using, conserving, and developing human resources to accomplish agency missions with minimum costs, and to meet national, social, and economic objectives.

1–3. SCOPE

a. The head of each agency will determine the extent of occupational health services to be provided at each work location. Occupational health programs ultimately will provide health services for all employees who work in groups of 300 or more, counting employees of all agencies who are scheduled to be on duty at one time in the same locality. Groups of less than 300 may be provided programs when the employing agency determines that working conditions involving unusual health risks warrant them.

b. An occupational health program which is largely preventive, deals with the health of employees in relation to their work. Definitive diagnosis and therapy of nonoccupational injury and illness are not responsibilities of the Federal employer, but where the Government, the employee, or the community stand to benefit, certain health measures may be provided to deal with nonoccupational illness or injury.

c. The health services that agencies are authorized to provide to employees are limited to those defined below. In determining whether a particular service is necessary, the working conditions and number of employees at each location will be considered.

(1) Emergency diagnosis and first treatment of injury or illness that become necessary during working hours and that are within the competence of the professional staff and facilities of the health service unit, whether or not the employee was injured while in the performance of duty or whether or not the illness was caused by his employment. When the necessary first treatment is outside the competence of the health service staff and facilities, the employee may be taken to a nearby

physician or suitable community medical facility at his request or at the request of someone acting on his behalf.

(2) Preemployment examinations of persons selected for appointment.

(3) Any in-service examinations of employees that the agency head determines to be necessary (in addition to fitness-for-duty examinations which are performed under existing authority).

(4) Administration, at the discretion of the responsible health service unit physician, of treatments and medications (a) furnished by the employee and prescribed in writing by his personal physician as reasonably necessary to maintain the employee at work and (b) prescribed by a physician providing medical care in performance-of-duty injury or illness cases under the Federal Employees' Compensation Act.

(5) Preventive services within the competence of the professional staff to (a) appraise and report work environment health hazards to agency management as an aid in preventing and controlling health risks, (b) provide health education to encourage employees to maintain personal health, and (c) provide those specific disease screening examinations and immunizations that the agency head determines to be necessary.

(6) In addition to the above, employees may be referred, upon their request, to private physicians, dentists, and other community health resources.

Subchapter 2. Agency Responsibilities

2–1. ROLE OF THE CIVIL SERVICE COMMISSION

The Chairman of the Civil Service Commission has the overall leadership role in developing and improving the health service programs for Federal employees in cooperation with the Secretary of Health, Education, and Welfare and the Secretary of Labor. Specifically, the Commission will:

- Assist agencies in developing adequate occupational health programs with services provided at work locations in the 50 States, the District of Columbia, the territories and possessions, and Puerto Rico.
- Set guidelines for cooperative provision of health services by two or more agencies having employees in the same or nearby buildings.
- Report annually to the President the extent, costs, and results of agency occupational health programs, together with an evaluation of these programs and appropriate recommendations. This will be done after
  - —Obtaining information from the agencies concerning the extent, staffing, facilities, and operating results of their programs.
  - —Consulting with the Public Health Service and the Department of Labor in their respective areas of responsibility.

2–2. ROLE OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

The Public Health Service (Division of Federal Employee Health) will:

- Provide consultative services on occupational medical standards and methods to agencies contemplating establishment of health service programs.
- Evaluate, upon request, agency health service programs in relation to PHS standards.
- Operate employee occupational health programs for other Federal agencies on a reimbursable basis when mutually agreeable.

2–3. ROLE OF THE DEPARTMENT OF LABOR

The Department of Labor will:

- Authorize medical and other services for employees who are injured or become ill in the performance of duty.
- Provide advice on the appraisal and elimination of health risks.

2–4. ROLE OF THE GENERAL SERVICES ADMINISTRATION

The General Services Administration will:

- Provide adequate space and fixed equipment for occupational health services for operation by the appropriate agency in space-planning, construction, and leasing activities under the Public Buildings Act and Federal Property and Administrative Services Act.

2–5. ROLE OF HEADS OF AGENCIES

The heads of agencies will:

- Review existing occupational health programs (also, see CSC responsibility for annual reports to the President).
- Consult with the Division of Federal Employee Health, PHS, about medical standards and methods before establishment of a program.
- In establishing a program, be consistent with Department of Labor standards and methods for providing medical services in performance-of-duty cases and for appraising health risks as authorized under the Federal Employees' Compensation Act.

Subchapter 3. Program Implementation

3–1. RELATIONSHIP TO MANAGEMENT

a. The greater the interest that management takes in occupational health the greater will be the benefits it yields. Failure to place an occupational health program at a high enough level in the agency organizational structure so as to insure it continued enlightened attention and support by management could seriously impair its efficiency, value, and yield. It is the responsibility of management to initiate or suggest improvements which appear to be indicated, and to maintain liaison with the Civil Service Commission, the Public Health Service, and the Department of Labor in the respective areas of responsibility.

b. Of particular importance is the establishment of a good working relationship between the professional head of occupational health services and the head of the work force served. Also important is the development of a meaningful reporting system to identify results and permit assessment of program effectiveness in terms of satisfying stated needs, reaching objectives, contributing to overall agency mission accomplishment, costs, and efficiency in the use of staff and resources.

3–2. MANAGEMENT RESPONSIBILITIES

a. Agency heads should issue clear policy statements, consistent with Bureau of the Budget Circular A–72, which show positive support of occupational health programs. Field establishments should also be given practical guidance on administrative matters necessary to establish or improve programs. As part of its required review of programs, top management should assure itself that all other levels of management are knowledgeable about occupational health, and should encourage special training where possible. The agency's occupational health policy is an appropriate subject for consultation and employee organization views should be solicited in accordance with FPM chapter 711.

b. Active management support of occupational health should take the form of assuring that employees know that use of available health services is encouraged, by making these services convenient, accessible during normal working hours, cost-free, and confidential. New employees should be informed about occupational health services as part of their initial orientation and all other employees reminded of them from time to time. When a new service is begun, or a special project such as immunizations is undertaken, management should show that it stands behind the program by ample publicity. Feedback from employees, union representatives, and supervisors on reactions to programs should be invited and discussed with the personnel office and the medical staff. Self-improvement and professional advancement of the staff of occupational health programs should be encouraged by helping medical personnel improve their skills and knowledge through special training and participation in professional associations. Programs should be adequately funded and staffed to enable them to meet realistic goals.

3–3. MANAGEMENT UNDERSTANDING OF OCCUPATIONAL HEALTH

Top management's understanding of the principles, methods, and goals of occuptional health should be advanced through two-way communication with the occupational health staff, familiarity with appropriate literature in the field, taking part in and observing programs in action, and participation in management-oriented training. Subchapter 4 of this chapter, which is an outline of occupational health objectives and methods, is designed to further management's working knowledge of the discipline.

but the occupational health physician also should be required to visit work areas to acquaint himself with their condition, environment, and health hazards so he can relate his services to job conditions. The Public Health Service also recommends the use of health unit personnel to help solve work-environment health problems.

- *Health examinations, both preplacement and periodic.* In addition to facilitating placement, examinations at intervals can determine whether an employee's health is compatible with his job assignment. Note that some tests, such as those for cervical cancer, glaucoma, renal disease, heart disease, and diabetes, are effective for younger persons and an age limit would be inappropriate. Speaking of this, the Commissioner of the Maryland Department of Health said before a United States Senate committee in 1966, "Certainly there are a number of diseases which afflict individuals . . . at an earlier age than 50, 40, or 30, and I would urge that [multiphasic screening, if adopted] be applied to all adults regardless of age. . . . I would like to emphasize what I feel is a need for including all adults in some type of overall preventive service." The Public Health Service recommends that cost benefit yield will be greatest in numbers of significant medical findings, when employees age 40 and older are given priority for selection. As an alternative, for sound preventive health practice, occupational health programs should freely incorporate voluntary health screening programs that are available to all employees for the early detection of chronic diseases or disorders.
- *Treatment of performance-of-duty injuries and illness.* These services must be limited by occupational health facilities established for the *sole* purpose of carrying out occupational health programs to those outlined in section 1–3 of this chapter. Services must be limited to emergency treatment and referral of injured employees to a hospital or physician designated by the Bureau of Employees' Compensation, Department of Labor, for needed further treatment. Any treatment beyond initial or emergency measures provided by the occupational health facility must be authorized by the physician or hospital providing medical care under the specific authorization of BEC. Medical facilities and physicians authorized by BEC to provide care to employees injured or ill in the performance of duty are listed in BEC pamphlet 576. See FPM chapter 810 for further information.
- *Treatment of nonoccupational illness and injury.* Emergency treatment should be provided as required to prevent loss of life or limb or to relieve suffering until placed under the care of the employee's personal physician. Treatment of minor disorders should be offered. The Public Health Service recommends only treatment of nonoccupational disorders which allows completion of the workday and provides interim care before arrangement for private medical attention. From the point of view of the individual employee's health needs, referral to a private physician or dentist is one of occupational health's most important activities.
- *Health education and counseling.* Health education and counseling enable management to derive maximum benefit from occupational health programs because it induces employees to be health conscious off the job as well as on the job.
- *Medical records.* Accurate continuing records contribute to better understanding of disorders when they occur. These records should be kept confidential. The Public Health Service's recommended policy is that (a) employee health records should be strictly confidential and filed in the health unit and (b) health records should not be released except by written permission of the employee, and then only to a medical facility or private physician. Any record may be obtained by an appropriate court order. See also FPM chapter 293 on filing, use, and disposition of medical records.

Subchapter 4. Basic Concepts of Occupational Health

4–1. GENERAL

a. Federal occupational health programs are designed to promote the health fitness of Federal employees for efficient performance of their assigned work. These programs, therefore, exist to serve management. The considerable benefit for employees is a by-product, but it has been substantial enough to influence unions to become a major force behind establishing occupational health programs in private industry.

b. Federal policy differs only slightly from the American Medical Association's philosophy as stated in its official publications. The material in section 4–2 is based directly on these publications.

4–2. MANAGEMENT BENEFITS

Among the management benefits of a good occupational health program are:

- *Reduction of absenteeism.* In this area alone a medical program which stresses *prevention* can make a tremendous contribution. *It is estimated that personal health problems account for 10 times as many absences as those caused by in-plant conditions.* For this reason, it is easy to see why the whole health picture of the employee is becoming a matter of increasing concern to every prudent employer.
- *Reduction of labor turnover.* A safe and pleasant working environment helps to keep employees in their jobs. A considerable investment is made in the training and instruction of each employee. This investment is completely lost when the employee leaves and industry must undertake duplicate training of his replacement.
- An increase in the useful span of years of both workers and management.
- *Contribution to good employee-management relations.* It is now well-established that an employee's productivity, the quality of his production, and his receptivity to management are largely determined by his morale and basic attitude.

4–3. PROGRAM OBJECTIVES

The objectives of an occupational health program are:

- To protect employees against hazards in their work environment.
- To facilitate placement.
- To assure adequate medical care and rehabilitation of the occupationally ill and injured.
- To provide health education and encourage personal health maintenance. There are advantages in being concerned with the whole health of the employee at least to the extent of advising him of preventive measures for his off-the-job health as well as on-the-job health, and by referring him to competent internists and specialists.
- To provide extra-occupational medical services, such as voluntary annual examinations and special preventive programs to avoid large scale absences. Prevention of nonoccupational illness is of primary importance since this kind of illness (e.g., colds and influenza) accounts for more absences than those of a purely occupational nature.

4–4. ACTIVITIES TO REACH OBJECTIVES

Prevention, rather than cure, characterizes occupational health programs. Certain essential preventive activities to attain the objectives of section 4–3 are:

- *Maintenance of a healthful work environment.* This should be accomplished by industrial hygienists' inspections and evaluations,

FPM-792 LETTERS AND ATTACHMENTS

792-1 Federal Employees Occupational Health Programs, 141

792-2 Limitations on Occupational Health Service Facilities in Treatment of Injury or Disease Sustained in the Performance of Duty, 163

792-3 Inspection Coverage of Federal Employees Occupational Health Program, 165

792-4 Federal Civilian Employee Alcoholism Programs, 172

792-5 Federal Employee Occupational Health Programs; Safeguarding Privacy of Participants, 185

PUBLISHED IN ADVANCE OF INCORPORATION
IN FPM CHAPTER 792
RETAIN UNTIL SUPERSEDED.

FPM LTR. NO. 792-1

UNITED STATES CIVIL SERVICE COMMISSION

FEDERAL PERSONNEL MANUAL SYSTEM

LETTER

Washington, D.C. 20415
March 16, 1970

FPM LETTER NO. 792-1

SUBJECT: Federal Employees Occupational Health Programs

Heads of Departments and Independent Establishments:

1. Public Law 79-658 (5 U.S.C. 7901), approved August 8, 1946, authorized heads of departments and agencies to establish health service programs for the purpose of promoting and maintaining the physical and mental fitness of employees of the Federal Government.

2. Since enactment of that public law, a number of interpretive documents and guides have been issued. This letter brings together in one reference source the informational issuances necessary in the development of occupational health programs. Also, responsibilities assigned to specific agencies for consultation, evaluation and reporting and the manner in which these functions will be accomplished have been highlighted.

Nicholas J. Oganovic

Nicholas J. Oganovic
Executive Director

Attachments

INQUIRIES: Regional Office or Bureau of Retirement, Insurance, and Occupational Health, Occupational Health Division, 63-25532 or Code 101, ext. 25532

CSC CODE 792-Health Program

DISTRIBUTION: FPM

Contents

I. Policy and Goals

II. Establishment and Scope of Employee Health Programs

III. Establishing Health Services

IV. Coordination and Evaluation

V. Appendixes

A. Public Law 79-658, as amended (5 U.S.C. 7901)

B. Bureau of the Budget Circular A-68, August 28, 1964

C. Bureau of the Budget Circular A-72, June 18, 1965

D. Title 29, Code of Federal Regulations, Chapter XIII, Part 1510 (29 CFR 1510)

E. Statement of Agency Responsibilities

F. Published Guides

Attachment to FPM Ltr. 792-1 (2)

I. Policy and Goals

The Act of August 8, 1946, as amended (5 U.S.C. 7901) is the basic authorization for providing health services to Federal employees. Bureau of the Budget Circular A-72 spells out Executive Branch policy for implementing the Act and establishes criteria to be followed by the heads of departments and agencies in providing programs of health services.

Circular A-72 establishes the policy that the health fitness of Federal employees for efficient performance of their assigned work is an important element in a progressive personnel management system and in effective administration of Federal programs. More specifically, the Circular encourages the establishment of occupational health programs to deal constructively with the health of employees in relation to their work and requires heads of departments and agencies to review existing programs in relation to the following goals:

- that such programs will ultimately be extended to all employees who work in groups of 300 or more, counting employees of all departments and agencies who are scheduled to be on duty at one time in the same locality and,

- that necessary health services may be extended to employees who work in groups of less than 300 where it is determined that working conditions involving unusual health risks warrant.

In addition to the program review requirement imposed on the heads of departments and agencies, the Circular provides that the Chairman of the Civil Service Commission will report annually to the President concerning occupational health programs. Such agency reviews and Commission reporting are dealt with in more detail under paragraph IV, Coordination and Evaluation.

II. Establishment and Scope of Employee Health Programs

The Public Law authorizes agency heads to establish programs after consulting with the Public Health Service and Circular A-72 requires that such programs be consistent with Department of Labor criteria. The following elaborates briefly as to these requirements. Further details can be obtained from or through CSC Regional Offices, from the CSC Bureau of Retirement, Insurance, and Occupational Health or directly from appropriate Public Health Service or Department of Labor offices.

- Consultation with PHS: Requests for consultation concerning medical standards and methods should be directed to the Division of Federal Employee Health, U.S. Public Health Service, Washington D.C. Agencies are encouraged to familiarize themselves with PHS

publications listed in the Appendix.

- Department of Labor Criteria: Agency occupational health program services must be consistent with standards and methods for providing medical services in performance-of-duty injury cases and for appraising health risks. These functions are authorized under the Federal Employees' Compensation Law .

- Information concerning performance-of-duty injury cases is contained in Title 20, Code of Federal Regulations, Chapter 1, Subchapter B, Part 2 and in the Federal Personnel Manual, Chapter 810.

- Information concerning appraising health risks is available at the Office of the Director, Bureau of Labor Standards, Department of Labor, and at Bureau of Labor Standards regional offices. The addresses of these offices are included in Appendix D to this letter.

Authorized occupational health services are limited to the following which are briefed in outline form. Circular A-72 (Appendix C) and PHS Publication 1325-A provide more complete information on these services:

- emergency diagnosis and first treatment of injury or illness that become necessary during working hours.

- pre-employment examinations of persons selected for appointment.

- in-service examinations.

- providing treatments requested by private physicians.

- preventive services including (1) preventing and controlling health risks, (2) health education programs and (3) specific disease screening examinations and immunizations.

- referrals to private physician or dentist based on preventive service findings.

III. Establishing Health Services

Bureau of the Budget Circular A-72 prescribes guidelines for providing health services from the standpoint of personnel, facilities, and space. The following briefly outlines these criteria and, additionally, discusses some important considerations for economical operation of occupational health services.

A. Methods for Obtaining Services

The guidelines provide three alternatives for establishing health service programs as follow:

1. By utilizing professional staff and facilities currently in existence.

This refers to agency activities whose mission or supporting activities include a medical facility e.g. Veterans Administration Hospitals, Public Health Service Hospitals, U.S. Navy or U.S. Army Hospitals, or military installations with medical treatment facilities.

2. By entering into an agreement with another Federal department that has available adequate staff and facilities.

This refers to joining with the type of activities used in the examples in Number 1 above on a per capita reimbursable or otherwise acceptable arrangement, or by joining with an agency or agencies in the same or nearby located buildings that have already established an occupational health program for employees.

3. Where neither of the preceding are currently available by

- establishing the department or agency's own professional staff and facilities.

- by entering into an agreement with qualified private or public sources for professional services.

B. Space Planning and Design of Facilities

Circular A-72 imposes the following requirements with respect to space planning, construction, and leasing activities:

1. That the Administrator of GSA, or agencies operating under delegated authority from the Administrator will make adequate space provision for occupational health services in accordance with GSA space standards (published in GSA, PBS Occupancy Guide for Federal Employee Health Units).

2. That heads of departments and agencies excluded from provisions of the Federal Property and Administrative Services Act will make adequate space provision for occupational health services (the GSA Occupancy Guide referred to in Number 1 is recommended).

C. Joint Use of Health Centers

Bureau of the Budget Circular A-68 (see Appendix B) specifically identifies health centers as one of the types of facilities that should be shared in Federal office buildings occupied by a number of executive agencies. Although Circular A-68 primarily addresses planning of proposed new buildings, Circular A-72 authorizes any agency that provides and maintains Federal space occupied with other agencies to provide central occupational health services under the policies and procedures of Circular A-68. Further, the Civil Service Commission, in Circular A-72, is charged with setting guidelines for cooperative provision of occupational health services by two or more agencies having employees in the same or nearby buildings and will, in rendering assistance to agencies, employ the guides in Circular A-68. The establishment and/or operation of Health Centers shared by two or more agencies may be under the administrative direction of any agency that uses the services.

D. Equipment

Diagnostic and laboratory equipment such as an EKG, fluoroscope diagnostic X-ray,etc., are authorized by Circular A-72 only where cost analysis and experience data show that maintenance of such equipment is more economical than securing such services from community facilities. PHS will, upon request, provide consultative service in this regard.

Where the agency head determines such service to be necessary, contact must be made with General Services Administration to determine availability of suitable excess property.

IV. Coordination and Evaluation

The Chairman of the Civil Service Commission is charged in Bureau of the Budget Circular A-72 with two primary responsibilities which are:

A. To assist agencies in the development of adequate occupational health programs with services provided at work locations in the States, the District of Columbia, the Territories, and Possessions and Puerto Rico.

Each CSC Regional Director has been directed to work constructively with agency field establishments in coordinating health service program efforts and the Division of Occupational Health, Bureau of Retirement, Insurance, and Occupational Health has been assigned such responsibility in the Washington, D.C. area.

The Civil Service Commission, in carrying out its assistance responsibilities will be acting in a service-facilitating capacity to the heads of agencies and their field establishment managers. This will include carrying out programs that will assure thorough, current knowledge of Employee Occupational Health Programs throughout the Executive Branch, coordinating the involvement of Public Health Service, Department of Labor, General Services Administration and other agencies in development of adequate agency occupational health programs and providing coordination in establishment of health centers that will contribute to economical and effective health services.

B. In addition to assistance responsibilities, Circular A-72 charges the Civil Service Commission with responsibility for reporting annually to the President the extent, costs, and results of departmental occupational health programs. In carrying out this responsibility, the Civil Service Commission will:

- obtain information from departments and agencies concerning the extent, staffing, facilities and operating results of their occupational health programs.
- analyze, in consultation with the Public Health Service and Department of Labor such agency programs and operating results.
- discuss findings with concerned agencies, particularly in terms of conditions that represent barriers in progress toward goals outlined in Circular A-72.
- report to the President on program results together with evaluation of departmental programs and with appropriate recommendations.

5 U.S. CODE 150 Appendix A

PUBLIC LAW 658 - 79TH CONGRESS

CHAPTER 865 - 2D SESSION

H.R. 2716

AN ACT

To provide for health programs for Government employees.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That, for the purpose of promoting and maintaining the physical and mental fitness of employees of the Federal Government, the heads of departments and agencies, including Government-owned and controlled corporations are authorized, within the limits of appropriations made available therefore, to establish by contract or otherwise, health service programs which will provide health services for employees under their respective jurisdictions: Provided, that such health service programs shall be established only after consultation with the Public Health Service and consideration of its recommendations, and only in localities where there are a sufficient number of Federal employees to warrant the provision of such services, and shall be limited to (1) treatments of on-the-job illness and dental conditions requiring emergency attention; (2) pre-employment and other examinations; (3) referral of employees to private physicians and dentists; and (4) preventive programs relating to health: Provided further, That the health program now being conducted by the Tennessee Valley Authority and by the Panama Canal and Panama Railroad Company shall not be affected by the provisions of this Act: And provided further, That such health programs as are now being conducted for other Federal employees may be continued until June 30, 1947. The Public Health Service, when requested to do so, shall review the health service programs being conducted by any department or agency under authority of this Act and shall submit appropriate comment and recommendations. Wherever the professional services of physicians are authorized to be utilized under this Act, the definition of "physician" contained in the Act of September 7, 1916, as amended (U.S.C., 1940 edition, title 5, sec. 790) shall be applicable.

Approved August 8, 1946

Attachment to FPM Ltr. 792-1 (8)

EXECUTIVE OFFICE OF THE PRESIDENT

BUREAU OF THE BUDGET Appendix B

WASHINGTON, D.C. 20503

AUGUST 28, 1964 CIRCULAR NO. A-68

TO THE HEADS OF EXECUTIVE DEPARTMENTS AND ESTABLISHMENTS

SUBJECT: Establishment of central supporting service facilities in headquarters and field office locations

1. Purpose. The purpose of this Circular is to provide policies and procedures under which central supporting services may be established in Federal office buildings occupied by a number of executive agencies, and operated where appropriate by the General Services Administration or other agencies.

The General Services Administration is currently providing various centralized services to Federal agencies in such fields as office and storage space, supplies and materials, communications, records management, and transportation services. Centralization of other supporting services or activities such as health units, printing and duplication shops, use of training devices and facilities, use of large conference rooms, and central facilities for receipt and dispatch of mail, may be feasible with resulting economies in personnel and space. Opportunities to effect economies through planned consolidations of such services occur particularly during the design stage of the construction of new Federal buildings. The objectives of this program are to increase efficiency and to achieve economies where a central supporting service facility can achieve these results without hampering program activities or essential internal administration of the agencies to be served.

2. Policies.

a. Executive agencies are encouraged and expected to cooperate fully in studies regarding prospective establishment of central services, and in the use of such services after establishment, as a means of achieving economies and improved utilization of manpower, equipment, and space. Agencies will be expected to discontinue similar services where a central support service is available.

b. Arrangements with regard to reimbursement will conform to existing law. Normally, reimbursement will be made for the use of

established services except where the cost is nominal or where reimbursement may not be practicable.

3. Studies to be conducted. The Administrator of General Services will conduct studies on his own initiative or at the request of an interested agency of locations where a centralized supporting service facility may be feasible. Before initiating any such study, the Administrator will give at least 30 days notice to the head of any executive agency that would be served by the proposed facility. Notice should contain an indication of cost elements involved, and indicate intended procedures to be followed in the study. The head of each executive agency receiving such notice will be asked to designate one or more officials at the location with whom representatives of the General Services Administration may consult, and to make available such information and assistance as is required or pertinent for an adequate review of the proposed installation.

If the Administrator determines, on the basis of such study, that establishment of the proposed facility is in accord with the objectives of this program, he will prepare a formal report to that effect. Where mutual agreement is reached, an agency other than GSA may be designated by the Administrator of General Services to administer the service or facility. Each report will include:

a. An explanation of advantages to be gained from the standpoints of increased economy, efficiency, and service, with due regard to the program and internal administrative requirements of the agencies to be served.

b. A comparison of estimated costs between the proposed centralized operation and separate agency operations. Estimated cost savings will be projected on an annual basis over a three year period.

c. A statement of the date such facility can be fully operational.

The Administrator will send a copy of this report to the head of each executive agency affected and to the Director of the Bureau of the Budget.

4. Establishment and Operation.

a. Negotiations, arrangements, and agreements for participation are primarily the responsibilities of the General Services Administration and the agencies involved. While a formal appeal procedure is believed unnecessary under this program, any agency desiring to explain its inability to participate may do so through a letter to the Director, Bureau of the Budget, with a copy to the Administrator of General Services.

(No. A-68)

b. Any proposed centralization of printing activities under this program will be in accord with the rules and regulations of the Joint Committee on Printing.

c. "Tenant Committees" will be established to assist GSA or such other agency as may be responsible for the administration and coordination of the facility or service.

d. Agency heads may bring problems of service and cost to the attention of the Administrator, who will give such problems prompt attention.

e. Services rendered by a facility established under this program may be discontinued or curtailed if no actual savings are realized from its operation during a reasonable period. Once established, a facility should be operated for a minimum of one year, in order to develop accurate cost information. The Administrator will consult with agencies in regard to timing of curtailment or discontinuance of any service and in any event shall give agency heads concerned at least 60 days notice before taking such action.

5. Development of program criteria. On the basis of experience under this program, the Administrator will develop criteria as to cost comparisons, production needs, size of building population, number of agencies involved, and other appropriate factors for consideration in determining the practicability of establishing various types of common services.

6. Budget Review. The costs, staffing and utilization of established central service facilities, similar facilities operated by non-participating agencies, and proposals for the establishment of new central services will be considered by the Bureau of the Budget in its annual review of budget requirements.

ELMER B. STAATS
Acting Director

(No. A-68)

Appendix C

EXECUTIVE OFFICE OF THE PRESIDENT
BUREAU OF THE BUDGET
WASHINGTON, D.C. 20503

June 18, 1965 Circular No. A-72

TO THE HEADS OF EXECUTIVE DEPARTMENTS AND ESTABLISHMENTS

SUBJECT: Federal Employees Occupational Health Service Programs

1. Purpose. Departments and agencies are authorized by the Act of August 8 1946, as amended (5 U.S.C. 150), to provide health service programs in order to promote and maintain the physical and mental fitness of employees under their respective jurisdictions. Departments and agencies have provided such health service programs subject to the "Policy Statement Covering the Establishment and Operation of Federal Employees Health Programs" approved by the President on January 9, 1950.

Federal employees who sustain personal injuries or disease while in the performance of duty are provided medical and other services, appliances, supplies, and vocational rehabilitation in permanent disability cases, under regulations of the Secretary of Labor. Departments and agencies undertake programs to eliminate health risks under the Federal Employees' Compensation Act, as amended (5 U.S.C. 751).

This Circular replaces the 1950 Policy Statement. It establishes criteria to be followed by the heads of executive branch departments and agencies in providing programs of health services under the 1946 Act, and in relating them to programs established to provide medical and other services and to eliminate health risks under the Federal Employees' Compensation Act.

2. Policy. The health fitness of Federal employees for efficient performance of their assigned work is an important element in a progressive personnel management system and in effective administration of Federal programs. The head of each department and agency, therefore, will review existing programs and is authorized and encouraged to establish an occupational health program to deal constructively with the health of the employees of his department or agency in relation to their work.

Such programs will ultimately provide employee health services of the scope specified in this Circular for all employees who work in groups of 300 or more, counting employees of all departments or agencies who are scheduled to be on duty at one time in the same locality.

(No. A-72)

Such programs may also provide one or more of the health services of the scope specified in this Circular for employees who work in groups of less than 300 where the employing department or agency determines that working conditions involving unusual health risks warrant such provision.

In localities with significant concentration of Federal activities and employees, health services may be supplied as a "central supporting service" when appropriate under the policies and procedures prescribed in Budget Circular A-68 dated August 28, 1964.

Treatment and medical care in performance-of-duty cases will continue to be provided to employees as provided in the Federal Employees' Compensation Act.

3. Establishment and operation of programs. Each department and agency head after consulting with the Public Health Service as to occupational medical standards and methods, and consistent with Department of Labor standards and methods for providing medical services in performance-of-duty injury cases and for appraising health risks as authorized under the Federal Employees' Compensation Act, is authorized to establish, within the limits of available appropriations, an occupational health program with health services to be provided as he deems necessary:

a. By utilizing professional staff or facilities existing in his department or agency at locations where adequate; or,

b. Where an agency's staff or facilities are not adequate, by entering into an appropriate agreement with another Federal department or agency at locations where that department or agency has available adequate professional staff or facilities; or,

c. Where neither the agency nor another Federal department or agency has adequate staff or facilities available, by establishing the department's or agency's own professional staff or facilities or by entering into an appropriate agreement with qualified private or public sources for professional services, including consulting services, or facilities.

The General Services Administration, the Post Office Department, or any other agency that provides and maintains Federal space occupied with other agencies where adequate health facilities are not provided by a tenant agency are authorized to provide occupational health services under this Circular for the employees of all such agencies working in groups of over 300 in the same locality, as provided for "central supporting services" under the policies and procedures of Budget Circular A-68 dated August 28, 1964.

(No. A-72)

Where the departments or agencies concerned jointly determine that the health services which are necessary due to working conditions involving health risks for fewer than 300 employees in the same locality cannot be adequately or economically supplied from qualified private or public sources by contract, they will be provided by means of a health service unit operated in Federal space.

4. Scope of occupational health services. Federal employee health services are authorized to be provided for all employees, consistent with the standard provided in paragraph 3, and will be limited to the occupational health services defined below.

The extent of these services to be provided at each work location will be determined by the head of the department or agency according to the working conditions and number of employees at that work location:

a. Emergency diagnosis and first treatment of injury or illness that become necessary during working hours and that are within the competence of the professional staff and facilities of the health service unit, whether or not such injury was sustained by the employee while in the performance of duty or whether or not such illness was caused by his employment. In cases where the necessary first treatment is outside the competence of the health service staff and facilities, conveyance of the employee to a nearby physician or suitable community medical facility may be provided at the request of, or on behalf of, the employee.

b. Pre-employment examinations of persons selected for appointment.

c. Such in-service examinations of employees as to the department or agency head determines to be necessary (in addition to fitness-for-duty examinations which are performed under existing authority).

d. Administration, in the discretion of the responsible health service unit physician, of treatments and medications (1) furnished by the employee and prescribed in writing by his personal physician as reasonably necessary to maintain the employee at work, and (2) prescribed by a physician providing medical care in performance-of-duty injury or illness cases under the Federal Employees' Compensation Act.

e. Preventive services within the competence of the professional staff (1) to appraise and report work environment health hazards to departmental management as an aid in preventing and controlling health risks; (2) to provide health education to encourage employees to maintain personal health; and (3) to provide specific disease screening examinations and immunizations, as the department or agency head determines to be necessary.

(No. A-72)

f. In addition to the above, employees may be referred, upon their request, to private physicians, dentists, and other community health resources.

5. Health service personnel, facilities, and space. Health services of the scope defined in paragraph 4 will be provided under the direction of a licensed physician, and nursing services will be provided by registered professional nurses. To the maximum extent feasible such physicians and nurses will be qualified in occupational medicine and nursing. The number of health service personnel and the types and extent of facilities provided at each work location where health services are furnished will be determined by the head of the department or agency according to the working conditions and the number of employees at the work location.

Diagnostic and laboratory equipment, other than hand instruments, of such cost and requiring such technical staff maintenance as an EKG, a fluoroscope, a diagnostic X-ray, or laboratory equipment used to analyze body fluids, may be maintained only in those large installations, particularly of an industrial nature, where cost analysis and experience data show that maintaining such equipment in the health service unit will be more economical than securing services from nearby community facilities.

Where the agency head determines it to be necessary to maintain such equipment, he will obtain it, wherever possible, from available Government excess property. The Administrator of General Services will advise departments and agencies, upon their request, concerning availability of excess Federal property suitable to their health service equipment needs.

Pursuant to the Public Buildings Act, as amended (40 U.S.C. 601 et seq.) and the Federal Property and Administrative Services Act, as amended (40 U.S.C. 471 et seq.), the Administrator of General Services in space planning, construction, and leasing activities, and in delegations of such activities to other agencies, will make adequate space provision for occupational health services under this Circular in accordance with space standards to be determined by the Administrator of General Services. Heads of departments and agencies excluded from the provisions of the Federal Property and Administrative Services Act or operating under delegated authority from the Administrator of General Services will also make adequate space provision.

6. Records

a. Medical records of persons selected for appointment and of individual employees, and professional evaluations, will be maintained under control of and for use only by the responsible professional personnel. When

requested by the employee, his full medical record will be made available by the physician in charge to a licensed physician designated by the employee.

b. The basis for any determinations made by departments and agencies as to (1) the need for and means of providing health services for employees working in groups of less than 300, (2) the need for in-service examinations, screening examinations and immunization, and (3) the need for and comparative costs of maintaining special diagnostic or laboratory equipment will be recorded.

7. Coordination and evaluation. The Chairman of the Civil Service Commission will assist the departments and agencies to develop adequate occupational health programs with services provided at work locations in the States, the District of Columbia, the Territories and possessions and Puerto Rico. He will also set guidelines for cooperative provision of such health services by two or more departments or agencies having employees in the same or nearby buildings where they find that joint action will result in providing more effective health services.

As authorized under the Act of August 8, 1946, the Public Health Service will advise departments and agencies, upon request, concerning their health service programs by providing agencies with occupational health standards to guide the provision of the occupational health services herein authorized, and by evaluating agency health service programs in relation to such standards. As authorized under the Federal Employees' Compensation Act, the Department of Labor will advise departments and agencies concerning the provision of medical services in performance-of-duty cases and the appraisal of work environment health risks.

The Chairman of the Civil Service Commission, after obtaining information from the departments and agencies concerning the extent staffing, facilities, and operating results of their occupational health programs, after consulting with the Public Health Service and with the Department of Labor in their respective areas of responsibility, and after such consultation with non-Federal occupational health program specialists as may be desirable, will report annually to the President the extent, costs, and results of departmental occupational health programs, together with an evaluation of such departmental programs and with appropriate recommendations.

CHARLES L. SCHULTZE
Director

(No. A-72)

390-537 (BB) O - 70 - 2

Attachment to FPM Ltr. 792-1 (16)

Appendix D

The following is an excerpt from Title 29 - Labor, in the Federal Register, Volume 33, Number 201, - Tuesday, October 15, 1968.

Section 1510.3 Safety and Health Standards

+++ (b) Information as to the latest standards, specifications, and codes, applicable to a particular situation and the references in Section 1510.2 is available at the Office of the Director, Bureau of Labor Standards, U.S. Department of Labor, 400 First Street N.W., Washington, D.C. 20210, or at any of the Regional Offices of the Bureau of Labor Standards as follows:

(1) North Atlantic Region, 341 Ninth Avenue, Room 920, New York, N.Y. 10001 (Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, Vermont, New Jersey, and Puerto Rico).

(2) Middle Atlantic Region, 1110-B Federal Building Charles Center, 31 Hopkins Plaza, Baltimore, Md. 21201 (Delaware, District of Columbia, Maryland, North Carolina, Pennsylvania, Virginia and West Virginia.)

(3) South Atlantic Region, 1371 Peachtree Street NE., Suite 723, Atlanta Georgia 30309 (Alabama. Florida, Georgia, Mississippi, South Carolina, and Tennessee).

(4) Great Lakes Region 848 Federal Office Building, 219 South Dearborn Street, Chicago, Illinois 60604. (Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin).

(5) Mid-Western Region, 1906 Federal Office Building, 911 Walnut Street, Kansas City, Mo. 64106. (Colorado, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, North Dakota, South Dakota, Utah, and Wyoming).

(6) Western Gulf Region, 411 North Akard Street, Room 601, Dallas, Texas 75201. (Arkansas, Louisiana, New Mexico, Oklahoma, and Texas).

(7) Pacific Region, 10353 Federal Building, 450 Golden Gate Avenue, Box 36017, San Francisco, Calif. 94102. (Alaska, Arizona, California Hawaii Nevada, Oregon, Washington, and Guam).

Appendix E

STATEMENT OF AGENCY RESPONSIBILITIES

This paper represents a general statement of responsibilities of the United States Civil Service Commission, the United States Department of Labor, the General Services Administration, and the United States Public Health Service, each of which has particular responsibilities in Federal employee occupational health service programs under Bureau of the Budget Circular A-72. The primary purpose of this paper is to clearly outline such responsibilities so that agency heads may be fully aware of areas of jurisdiction and effectively utilize available services in providing adequate occupational health services to their employees.

Background

Departments and agencies are authorized by the Act of August 8, 1946 as amended (5 U.S.C. 7901), to provide health service programs in order to promote and maintain the physical and mental fitness of their employees.

Bureau of the Budget Circular A-72, dated June 18, 1965, encourages the establishment of occupational health programs and specifies criteria to be followed in providing programs of health services under the 1946 Act.

Responsibilities

The following outlines in brief form the requirements and responsibilities imposed by Bureau of the Budget Circular A-72.

1. Heads of Departments and Agencies must:

- review existing occupational health programs (also, note CSC responsibility for annual reports to the President)
- consult with the Division of Federal Employee Health, PHS, as to medical standards and methods before establishment of a program
- in establishing a program, be consistent with Department of Labor standards and methods for providing medical services in performance-of-duty cases and for appraising health risks as authorized under the Federal Employees' Compensation Act

2. The Chairman of the Civil Service Commission will:

- assist the departments and agencies to develop adequate occupational health programs with services provided at work locations in the States, the District of Columbia, the Territories and possessions, and Puerto Rico

- set guidelines for cooperative provision of health services by two or more departments or agencies having employees in the same or nearby buildings

- report annually to the President the extent, costs, and results of departmental occupational health programs, together with an evaluation of such departmental programs and with appropriate recommendations. This will be done after:

  - obtaining information from the departments and agencies concerning the extent, staffing, facilities, and operating results of their programs

  - after consulting with the Public Health Service and with the Department of Labor in their respective areas of responsibility

Special Note:

Circular A-72 is specifically limited to occupational health services provided for Federal employees. However, because of the interrelationship of occupational health programs and safety programs, the Civil Service Commission will be supportive of the Department of Labor and the Federal Safety Council programs for eliminating work hazards and health risks. The Commission will provide support by cooperating in the sponsorship of promotional and motivational efforts such as:

- reviewing agency efforts to build into their personnel policies and operations appropriate attention to carrying out the safety promotion activities envisaged in Section 33 of the Federal Employees' Compensation Act

- sponsoring safety training courses, and encouraging the inclusion of safety training in the broad personnel training courses

- such other means as are available within Civil Service Commission capabilities

3. The Public Health Service (Division of Federal Employee Health) will:

- provide consultative services to agencies contemplating establishment of health service programs as to occupational medical standards and methods

- evaluate, upon request, agency health service programs in relation to PHS standards

- operate employee occupational health programs for other Federal agencies on a reimbursable basis where mutually agreeable

4. The Department of Labor will:

- authorize medical and other services for employees who sustain personal injury or disease in the performance of duty

- provide advice concerning the appraisal and elimination of health risks

Special Note:

Because of the interrelationship of the Federal Occupational Health Program and the safety programs, the following responsibilities of the Department of Labor and the Federal Safety Council in the area of safety are reviewed here:

The Labor Department administers the Federal Employees' Compensation Act for all Federal civilian employees. The act delegates to the Secretary of Labor responsibilities for the promotion of accident and injury prevention programs in the Federal Government. The Secretary can and does prescribe statistical and other types of reports relating to accident prevention which are furnished by the agencies to assist him in his leadership responsibilities under the act. The Department of Labor provides consultative services, safety program evaluations, safety training, and other accident prevention programming activities to Federal agencies.

The Federal Safety Council is advisory to the Secretary of Labor, who in turn reports directly to the President on matters affecting the safety of Federal civilian employees. The Council, established by Executive Order 10990 guides the Secretary as to the development and maintenance of adequate and effective Federal accident prevention programs, particularly with respect to criteria, standards, and procedures. Approximately 55 Government agencies are represented on the Council and participate in its actions. Agency members serve on the various working divisions and committees which deal with such subjects as Training and Education, Accident Records, Motor Vehicle and Traffic Safety and Standards. The Council has extended its safety coordination to the field through the establishment and continuing guidance of approximately 100 field affiliates. The Secretary of the Federal Safety Council is provided by the Department of Labor.

5. The General Services Administration will:

provide adequate space and fixed equipment for occupational health services in space planning, construction and leasing activities under the Public Buildings Act and Federal Property and Administrative Services Act, ready for operation by the appropriate agency.

Appendix F

PUBLICATIONS AND REFERENCES ON FEDERAL EMPLOYEE OCCUPATIONAL HEALTH SERVICES PROGRAM

1. Health Services for Federal Employees, A Prospectus, PHS Publication No. 1852

2. An Administrative Guide for Federal Occupational Health Units, PHS Publication No. 1325-A (Rev.)

3. Occupancy Guide-Federal Employee Health Units, GSA, PBS Publication Rev. Sept. 1955

4. The First Step, Report on a Conference on Drinking Problems CSC, April 1968

5. The Key Step, A Model Program to Deal with Drinking Problems of Employees, CSC, January 1969

PUBLISHED IN ADVANCE OF INCORPORATION
IN FPM CHAPTER 792
RETAIN UNTIL SUPERSEDED.

FPM LTR. NO. 792-2

UNITED STATES CIVIL SERVICE COMMISSION

FEDERAL PERSONNEL MANUAL SYSTEM

LETTER

Washington, D.C. 20415
June 12, 1970

FPM LETTER NO. 792-2

SUBJECT: Limitations on Occupational Health Service Facilities in Treatment of Injury or Disease Sustained in the Performance of Duty

Heads of Departments and Independent Establishments:

1. The purpose of this letter is to clarify the conditions under which occupational health facilities are authorized to provide treatment in connection with injuries incurred by employees in the performance of their official duties. This clarification should be brought to the attention of physicians with responsibility for operating agency occupational health facilities to assure that the provisions of the Federal Employees' Compensation Act /5 U.S.C. 8101 et seq./ are observed.

2. Physicians in charge of occupational health facilities should be familiar with FPM chapter 810 entitled Injury Compensation. This chapter was developed by the Department of Labor which, through the Bureau of Federal Employees' Compensation, administers and decides all questions arising under the law. Occupational Health facilities are authorized by the Bureau of the Budget in Circular A-72 to provide specifically limited services which fall within the Federal employees' compensation law. They are:

   - Emergency diagnosis and first (initial) treatment of injury or illness sustained in the performance of official duties and

   - Administration of treatments and medications prescribed (and authorized) by a physician providing medical care in performance-of-duty injury or illness cases under the Federal employees' compensation law.

   Simply put, occupational health facilities must limit services in performance of duty injuries and illnesses to emergency treatment and refer the injured employees to a hospital or physician designated by the Bureau of Employees' Compensation for needed further treatment--and any treatment beyond initial or emergency measures provided by the occupational health facility must be authorized by the physician or hospital providing medical care under the specific authorization of the BEC.

INQUIRIES: Regional office or Bureau of Retirement, Insurance, and Occupational Health, Occupational Health Division, 63-25532 or code 101, ext. 25532

CSC CODE 792- Health Program

DISTRIBUTION: FPM

3. Medical facilities and physicians authorized by BEC to provide continuing care to injured employees are listed in BEC pamphlet 576; in addition to PHS hospitals that are listed, the Department of Labor states in FPM chapter 810 that the medical facilities of the Army, Navy, Air Force, and Veterans Administration may be used on a case-by-case basis when previous arrangements have been made with the director of the medical facility. Accordingly, the physicians and PHS hospitals listed in pamphlet 576 plus Department of Defense medical facilities referred to above are the sources authorized by BEC to provide or prescribe continuing medication and treatment for employees injured in the performance of duty.

   The important distinction in the foregoing is the fact that agency facilities established for the sole purpose of carrying out occupational health programs are not authorized to exceed the limits of the services as outlined in BOB Circular A-72 and as clarified in this letter.

4. BEC Pamphlet 576, Medical Facilities, is issued by the Bureau of Employees' Compensation through the normal distribution channels of each Federal agency. For further information contact the Bureau of Employees' Compensation, Washington, D. C. 20211, or one of the Bureau's district offices (see FPM Chapter 810, Injury Compensation, for listing of these offices).

5. All questions pertaining to medical care in instances of injury or illness in the performance of duty should be addressed to the Bureau of Employees' Compensation at the addresses indicated above.

Nicholas J. Oganovic

Nicholas J. Oganovic
Executive Director

This material has been prepared in cooperation with the United States Department of Labor. General questions about the laws covering injury compensation should be directed to agency personnel officers or to any office of the Bureau of Employees' Compensation. Questions about specific cases should be addressed to the Bureau's district office responsible for adjudicating the claim.

Questions concerning occupational health programs should be directed to any CSC regional office or to the Bureau of Retirement, Insurance, and Occupational Health, Occupational Health Division.

PUBLISHED IN ADVANCE OF INCORPORATION
IN FPM CHAPTER 792
RETAIN UNTIL SUPERSEDED.

FPM LTR. NO. 792-3

UNITED STATES CIVIL SERVICE COMMISSION

FEDERAL PERSONNEL MANUAL SYSTEM

LETTER

Washington, D.C. 20415
June 16, 1970

FPM LETTER NO. 792-3

SUBJECT: Inspection Coverage of Federal Employees Occupational Health Program

Heads of Departments and Independent Establishments:

1. The purpose of this letter is to provide a copy of the agenda that will be used, commencing July 1, 1970, in the review of the occupational health portion of agency personnel management programs.

2. Issuances cited in the agenda which relate to occupational health can be found in FPM Letter No. 792-1, dated March 16, 1970.

Nicholas J. Oganovic

Nicholas J. Oganovic
Executive Director

Attachment

INQUIRIES: Regional offices or Occupational Health Division, Bureau of Retirement, Insurance, and Occupational Health, 63-25532 or code 101, ext. 25532

CSC CODE 792 - Health Program

DISTRIBUTION: FPM

Attachment to FPM Ltr. 792-3

FPM Supplement (Internal) 273-72

S4-4 Utilizing the Workforce

* * * *

(13) Federal Employees Occupational Health Program

(a) Background

FPM Chapter 250 identifies the maintenance of an employee occupational health program as an action managers should take in conserving and utilizing manpower resources. This mandate was provided a foundation in law in August 1946, with the enactment of P. L. 658 which authorized the heads of departments and agencies to establish health services programs "to promote and maintain the physical and mental fitness" of Federal employees.

The Commission's responsibilities in the area of occupational health were established in June 1965 with the issuance of Bureau of the Budget Circular A-72. That issuance directs the Commission to assist the departments and agencies to develop adequate occupational health programs and to report annually to the President the extent, costs, and results of departmental programs, together with an evaluation and appropriate recommendations. Circular A-72 also establishes criteria to be followed by heads of executive branch departments and agencies in providing programs of health services under the 1946 Act and defines consultative and service roles assigned the Public Health Service and General Services Administration.

Briefly, the services authorized by the 1946 Act and Circular A-72 are:

1 emergency diagnosis and first treatment of injury or illness that become necessary during working hours.

2 pre-employment examinations of persons selected for appointment (within the limitations of FPM Chapter 339).

3 employee health maintenance examinations (periodic physicals).

4 providing treatment requested by private physicians.

5 preventive services including (1) preventing and controlling health risks, (2) health education programs, and (3) specific disease screening examinations and immunizations.

6 referrals to private physician or dentist based on preventive service findings.

The Commission is carrying out its overall occupational health program activities through the Division of Occupational Health of the Bureau of Retirement, Insurance, and Occupational Health. Each of the Commission's regions has an Occupational Health Representative whose major role is to render assistance to agencies throughout the region in the development of adequate occupational health programs within the purview of Circular A-72.

In the field, inspection coverage of occupational health programs will be designed to supplement the promotional activities of the Occupational Health Representative as well as to provide feedback to headquarters agency officials and to key Commission officials on the scope, content, and effectiveness of agency occupational health programs. Inspectors should become thoroughly acquainted with the material in FPM Chapter 792 which brings together, in one reference source, information on the Federal Employee Occupational Health Program. Also, continuing and close coordination with the Occupational Health Representative should be maintained throughout the review process.

(b) Coverage

The language of Circular A-72 establishes the frame of reference within which the inspector should approach review of agency occupational health programs. Specifically, it establishes the following policy:

"The health fitness of Federal employees for efficient performance of their assigned work is an important element in a progressive personnel management system, and in effective administration of Federal programs. The head of each department, therefore, will review existing programs and is authorized and encouraged to establish an occupational health program to deal constructively with the health of the employees of his department or agency in relation to their work+++"

The Commission regards the review responsibility imposed on agency heads as a continuing requirement that should be carried out as an integral part of the agency's internal evaluation of personnel management. A most meaningful consideration in this respect is whether a policy or other formal statement has been issued by the head of the agency to field establishments. The absence of such a policy statement should be brought to the attention of BRIOH via the BI transmittal memorandum. Where such policies have been issued, a thorough evaluation should be made of implementation steps taken by the head of the field establishment together with results.

The issue of adequacy of health services necessarily depends upon the particular needs of the activity being reviewed (industrial setting, office setting, special occupational disease hazard, etc.). The range of services authorized by Circular A-72 represent the basic framework of services that generally apply to any type or size activity, but necessarily should be tailored for emphasis to the work environment, occupational disease hazards, as well as patterned to the needs of the workforce. In this regard the inspector should focus particularly on steps taken to evaluate such needs and on follow-up, where programs exist, to insure program objectives are being met.

In those activities that operate and/or share occupational health facilities, factfinding should include reviewing health facility activity reports to management, medical staffing complement, extent of physical occupational health plant and accessibility by employees, costs of operating the program and manner of funding. In those activities

that do not have programs, close inquiry should be made with the head of the installation (or his designee for occupational health), as to the extent of his authority to commit money, personnel and other resources for occupational health, and the headquarters official to whom he must go for expenditures beyond his authority.

Although A-72 arbitrarily limits establishment of programs to locations where there are at least 300 employees, counting employees of all departments and agencies, the fact cannot be ignored that management investment in employees who work in smaller groups is equally great. Special attention should be given to identifying the extent to which employees are remotely stationed and actions taken or contemplated to extend at least minimal occupational health services. Simple solutions are seldom available in such cases and the counsel of the Regional Occupational Health Representative should be obtained in proposing courses of action to managers or to work with agency managers in the development of long range solutions.

In addition to identifying what occupational health services are available, inspectors should be alert to the kind of relationship that exists between top management and the occupational health facility. Paragraph 5 of Circular A-72 stipulates that health services will be provided under the direction of a licensed physician. This requirement presupposes the same relationship between the Medical Officer and top management as exists between the manager and his other key staff people. This concept applies equally where a health facility provides services to several agencies; inspectors should review the kind of program feedback and advice given managers by heads of occupational health facilities. As in other personnel management program activities, inspectors should focus on efforts concerned with advance planning of a program of effective and needed services, and periodic evaluation of the quality and scope of services provided including the extent to which the workforce uses the available occupational health services.

Inspectors should be particularly alert to any innovative or particularly successful approaches agencies have developed to extend health services to employees. For example, methods developed for providing services to remotely stationed employees, alcoholism or drug abuse programs, educational programs etc. should be described in sufficient detail to enable publicizing the program for other agencies to consider.

(c) Factfinding methods and procedures

Initial contacts for program information should be made with the establishment's occupational health officer if one has been designated or other staff official charged with occupational health program development. If no such official has been designated, and particularly in the absence of any program of occupational health services, information on program status, future plans, etc. should be obtained from the head of the local establishment.

Where activities have the services of a health facility available, contact should be made with the Medical Officer or other official in charge for information on services provided along with education, alcoholism, drug abuse, or similar programs.

Interviews with managers, supervisors, and employees should include inquiry into the effectiveness of communication of the service available in the health facility, and support and acceptance of service on the part of supervisors and employees.

Inspectors should obtain answers to these and related questions through interviews, record reviews, and other appropriate factfinding means:

- Do the installation's employees have access to a health unit? If no unit is accessible, why? Is one available within a reasonable distance?

- Are available occupational health services and/or facilities adequate in relation to the types of work performed at the installation? If not, what difficulties and problems exists? What efforts are being made to improve the extent or scope of existing services or facilities?

Attachment to FPM Ltr. 792-3 (6)

- What is management's policy and attitude toward programs aimed at systematically aiding alcoholics and persons with emotional or mental problems? Do such programs exist in the installation (either independently or in connection with a health unit operation)?

- What is the nature of the services available? i.e., counseling, in-house psychiatric care, referrals, etc. Who provides counseling? How are counselors selected and trained.

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ADVANCE EDITION

FPM LTR. NO. 792- 4

UNITED STATES CIVIL SERVICE COMMISSION

FEDERAL PERSONNEL MANUAL SYSTEM

LETTER

Washington, D.C. 20415
July 7, 1971

FPM LETTER NO. 792- 4

SUBJECT: Federal Civilian Employee Alcoholism Programs

Heads of Departments and Independent Establishments:

1. Public Law 91-616 (42 U.S.C. 4551 et. seq.) approved December 31, 1970, provides that the Civil Service Commission shall be responsible for developing and maintaining, in cooperation with the Secretary of Health, Education and Welfare and with other Federal agencies and departments, appropriate prevention, treatment and rehabilitation programs and services for alcoholism and alcohol abuse among civilian employees.

2. Proposed guidelines for implementation of Federal programs were circulated for comment on April 1, 1971. Suggestions received were considered in developing the final guidelines attached to this letter.

3. The head of each department and agency with Federal civilian employees shall issue implementing internal instructions consonant with these guidelines by December 1, 1971. A copy of departmental and agency headquarters level internal instructions should be forwarded to the Bureau of Retirement, Insurance and Occupational Health by December 15, 1971.

Bernard Rosen

Bernard Rosen
Executive Director

Attachments

INQUIRIES: Regional Office or Bureau of Retirement, Insurance, and Occupational Health, Occupational Health Division, 63-25532 or Code 101, ext. 25532

CSC CODE 792 - Health Program

DISTRIBUTION: FPM (advance edition limited)

Contents

I. Background

II. Purpose

III. Implementation

IV. Policy

V. Definition of the Alcohol Problem

VI. Program Guidelines

VII. Relationship to Disciplinary Actions

VIII. Records and Reports

IX. Use of Sick Leave

X. Expenses of Rehabilitation

XI. Eligibility for Disability Retirement

XII. Employment Considerations

XIII. Acknowledgements and Recommended Source Material

I. Background

Section 201 of Public Law 91-616 provides that the Civil Service Commission shall be responsible for developing and maintaining, in cooperation with the Secretary of Health, Education and Welfare and with other Federal agencies and departments, appropriate prevention, treatment and rehabilitation programs and services for alcoholism and alcohol abuse among civilian employees.

II. Purpose

This issuance transmits to the heads of departments and agencies the guidelines for implementation of Public Law 91-616. These guidelines were developed in consultation with the Secretary, HEW, heads of agencies and the national labor organizations. The guidelines are purposely broad to permit development of programs by each department and agency that are most likely to provide effective rehabilitation opportunity to employees with problems relating to their use of alcohol.

III. Implementation

All agencies employing Federal civilian employees shall issue implementing internal instructions within the purview of these guidelines by December 1, 1971. Inherent in applying these guidelines is the understanding that there is no one "best" way to deal with alcoholism or problem drinking in the employment setting.

IV. Policy

As an employer, the Federal government is not concerned with the private decision of an employee to use or not to use alcoholic beverages. The use of alcoholic beverages is of concern to management only when it results either directly or indirectly in a job-related problem. A drinking problem exists when an employee's use of alcohol interferes with the efficient and safe performance of his assigned duties, reduces his dependability or reflects discredit on the agency. In such cases, Federal managers will take action in the form of (1) nondisciplinary procedures under which an employee with a drinking problem is offered rehabilitative assistance and (2) failing response which results in acceptable work performance, invoking regular disciplinary procedures for dealing with problem employees.

V. Definition of the Alcohol Problem

Alcoholism and the misuse of alcohol are sufficiently widespread that few of our social institutions escape their effects. Alcoholism is an illness affecting large numbers of Americans and is in no way restricted to persons in any particular economic, social, or occupational strata. The relationship of problem drinking to illness, accidents, crime, poverty, and a myriad of other problems

is becoming well known. Less well known is the impact of alcohol on the employer and the workplace. However, the Comptroller General's report on the effect of alcoholism among Federal civilian employees estimated that payroll losses in the Federal service alone may amount to as much as $550 million annually.

Alcoholism needs to be placed in perspective. In its Manual on Alcoholism published in 1967 the American Medical Association termed alcoholism as "a highly complex illness" and addressed the treatability of alcoholics as follows:

> "Alcoholics are treatable patients. Because their illness is a chronic disorder with tendency toward relapse, it should be approached in much the same manner as are other chronic and relapsing medical conditions. The aim of treatment is then viewed more as one of control than cure. Abstinence is sought as a primary objective, but additional considerations, such as improved social or occupational adjustments, may be far better guides in evaluating the success or failure of a treatment effort. Temporary relapse with return to drinking, then, should not be equated with failure, any more than should the diabetic's occasional discontinuation of his diet or his insulin."

Several definitions that further serve to place the alcohol problem in perspective are the following:

Alcoholism: A chronic disease characterized by repeated excessive drinking which interferes with the individual's health, interpersonal relations, or economic functioning. If untreated, alcoholism becomes more severe and may be fatal. It may take several years to reach the chronic phase.

Alcoholic: An individual who has the illness alcoholism. His drinking is out of control and is self-destructive in many different ways. The term "recovered alcoholic" also describes the person who has undergone rehabilitation and whose disease has been arrested through abstinence.

Problem Drinker: To management, a problem drinker is any employee whose use of alcohol frequently affects his work adversely.

VI. Program Guidelines

A. Program Support and Endorsement

Agency programs should be designed to bring the problem into the open, and to inform all employees and managers of the Congressional policy established in the new law so that the social and moral stigma

are removed and the employee with a drinking problem or suffering from alcoholism will be encouraged to seek help.

A policy statement is one of the most important features of any program designed to deal with problem drinking among employees. An official statement issued by top management and understood all the way down the supervisory line is necessary so that all employees know that the program has full management support. It is a vital step toward obtaining optimum operation of the program.

Some agencies, in the past, have expressed a preference for operating their programs in a quiet, unofficial manner. Experience has shown that unless a formal policy is written and public, [illegible] doubts occur about the sincerity of management in operating the program. Management need not be embarrassed about facing up to a [illegible] problem; indeed, there is more embarrassment inherent in "[illegible]ng up" or "dealing unofficially" with a problem caused by an illness. Even if a small agency is unaware of any employees with drinking problems a formal and public statement is necessary to define what shall be done if, in the future, the agency encounters such a problem. Alcoholism, as a health condition, does not need to be hidden away.

B. Policy Statements

Policy statement should include the following declarations:

1. That the agency recognizes alcoholism as a treatable illness.

2. That for the purposes of the policy, alcoholism is defined as an illness in which the employee's job performance is impaired as a direct consequence of the abuse of alcohol.

3. That employees having the illness or other problems relating to the use of alcohol will receive the same careful consideration and offer of assistance that is presently extended to employees having any other illness.

4. That the agency is not concerned with the employee's use of alcohol except as it may affect his job performance or the efficiency of the service.

5. That no employee will have his job security or promotion opportunities jeopardized by his request for counseling or referral assistance, except as limited by Title II, Section 201(c)(2) of P.L. 91-616 relating to sensitive positions.

6. That the confidential nature of medical records of employees with drinking problems will be preserved in the same manner as all other medical records.

7. That sick leave will be granted for the purpose of treatment or rehabilitation as in any other illness.

8. That employees who suspect they may have an alcoholism problem, even in the early stages, are encouraged to voluntarily seek counseling and information on an entirely confidential basis by contacting the individual(s) designated to provide such services.

C. Relationships With Labor Organizations

The support and active participation of labor organizations will be a key element to the success of an alcoholism program. Union officers and stewards who represent the employee concerning working conditions and personnel policy will also be influential in creating employee confidence in management's alcoholism policy. It is therefore essential that labor organizations understand management's sincere commitment to assist the employee with his drinking problem. Management should make it clear to union officials that an employee will be extended maximum assistance toward rehabilitation. However, it must also be understood that when the employee fails to raise his job performance to an acceptable level, appropriate action will be taken.

In order to assure the cooperation and support of labor organizations, management should deal with union representatives on program policy formulation, and maintain open lines of communication with union leaders. Union representatives, for example, could be included in briefing sessions or other training and orientation programs so that there will be mutual understanding of policy, referral procedure and other elements of the alcoholism program.

D. Program Direction

Once a policy and plan has been approved, it is important that there be continuing coordination and assessment of program activities. To accomplish this a Program Administrator should be designated at the headquarters level to direct the program on an agencywide basis. Additionally, an individual should be designated at each field installation to coordinate local operations of the program. Individuals selected for such assignments should be allotted sufficient official time to effectively implement the agency policy and program including bringing education and information to the work force, arranging or conducting supervisory training, developing and maintaining counseling capability (personnel, medical or other counseling resources), establishing liaison with community education, treatment and rehabilitation facilities, and evaluating the program and reporting to management on results and effectiveness.

Headquarters and field installation program personnel should be organizationally located so as to enable an overview of how the agency's efforts to deal with problem drinking are executed by the personnel, medical, and other functions assigned program responsibilities.

There is no special need to seek out recovered alcoholics to assume key roles, although some recovered alcoholics perform in an excellent manner because they are strongly motivated and knowledgeable in this area. However, if a recovered alcoholic is assigned as a Program Administrator or Program Coordinator, he should be familiar with treatment methods other than the one that was successful for him. It is just as essential that the individual selected be an experienced and effective administrator.

E. Role of the Personnel Office

Executive Order 9830 requires the head of each agency to designate a director of personnel to provide advice and assistance to him in carrying out his personnel management responsibilities. This director represents the agency head in personnel matters; consults with him on personnel policy matters; and develops, implements, and reviews the agency's personnel programs.

Chapter 250 of the Federal Personnel Manual cites the foregoing and identifies occupational health and alcoholism programs as elements of manpower utilization in which the manager, with the assistance of the personnel officer, should take action in carrying out these program responsibilities.

Accordingly, the personnel director and his organization should be assigned key program development, implementation, and review responsibilities consistent with responsibilities in other personnel management functions.

F. Community Resources

An effective alcoholism program should be tied to the community resources that are concerned with treatment of alcoholism. An important first step is identifying and establishing working relationships with community programs and resources which deal with information and education, treatment and rehabilitation. Such organizations typically include Alcoholics Anonymous groups, Al-Anon for the family members of persons with drinking problems, Al-A-Teen for the children of alcoholics, hospitals willing to admit patients with drinking problems, alcoholism information centers sponsored by organizations such as the National Council on Alcoholism, physicians interested in working with alcoholics, State or local government alcoholism clinics, and similar organizations. Information on local resources should be maintained on a current basis and be readily available to individuals providing counseling services to employees who may have drinking problems.

In those instances where a number of agencies are represented in a community, it is recommended that Federal managers coordinate their contacts with treatment and educational facilities in order to further the concept of a united Federal effort to deal with problem drinking

and alcoholism. In this regard, the use of FEB's, FEA's, labor organizations, or similar approaches should be considered in establishing communications in this program. Also, other employers including local government and private industry should be invited to participate in community surveys, liaison and similar activities related to dealing with alcoholism.

G. Role of the Supervisor

While alcoholism is not an occupational disease, it manifests itself in the form of poor work performance at the place of employment. Losses to the employer take the form of poor workmanship, errors in judgment, and absenteeism. The work setting offers definite advantages in dealing with problem drinking and alcoholism. Management and supervisors recognize the value of keeping a trained employee. Recognition that a valued employee has an illness raises this awareness. Early identification and rehabilitation of the worker with a drinking problem depend largely upon the efforts of nonmedical persons such as counselors and supervisors in particular. Unless the physician has the help of these individuals, his chances of helping the alcoholic or person with a drinking problem are greatly reduced.

1. Key Role of the Supervisor

The supervisor has a key role to play in making an agency program effective. Usually he is the only representative of management who has a close enough relationship to the employee to realize the existence of a problem that may be caused by drinking. However, the supervisor does not diagnose alcoholism; that is a decision for the physician.

When an employee does not appear to be in full control of his faculties the supervisor should immediately inquire about his physical condition but should be aware that appearance symptoms usually related to intoxication can apply to other illnesses as well. For example, tremors (shakes) can be a sign of thyroid imbalance, Parkinsonism or multiple sclerosis to name but a few; a flushed face, excessive perspiration, a tendency to slur words or a stagger in walking can also signify the presence of diseases which may not necessarily be related to alcoholism or drinking problems. Information on such cases should be relayed to the physician and the employee should be referred to the medical department, when appropriate, for emergency treatment and, where indicated, referred to the private physician or community health services. In the event such cases ultimately are determined to have stemmed from abuse of alcohol, counseling services should be offered the employee.

In summary, the supervisor is responsible for determining what constitutes satisfactory work performance by carrying out the following basic functions:

a. To be alert, through continuing observation, to changes in the work and/or behavior of assigned employees.

b. To document specific instances where an employee's work performance, behavior or attendance fails to meet minimum standards or where the employee's pattern of performance appears to be deteriorating.

c. To consult with the medical and/or counseling staff for advice on probable causes of the employee problem.

d. To conduct an interview with the employee focusing on poor work performance and informing the employee of available counseling services in the event poor performance is caused by any personal problem.

e. If the employee refuses help and performance continues to be unsatisfactory, he is given a firm choice between accepting agency assistance through counseling or professional diagnosis of his problem, and cooperation in treatment if indicated, or accepting consequences provided by agency policy for unsatisfactory performance.

2. Development of Supervisors

To properly equip supervisors to carry out their critical role agencies should specifically acquaint all supervisors, managers, representatives of employee organizations, and ultimately every employee with the agency policy and program for dealing with alcoholism. To be supportive of the alcoholism program and contribute to increased supervisory effectiveness generally, agencies should take positive action in the development of supervisory skills in identifying deteriorating performance in employees and carrying out counseling responsibilities on the basis of job performance. Additionally, agencies should orient supervisors on the importance of firm and consistent application of corrective procedures and disciplinary policies as they relate to the alcoholism program.

H. Role of the Medical Department

1. Emergencies

Under the provisions of Office of Management and Budget Circular A-72 agencies may provide, as a part of the Federal Employee Occupational Health services, emergency diagnosis and first treatment of injury or illness that become necessary during working hours.

2. Counseling

In addition to emergency cases, the medical department should have the capability to provide consultation to supervisors in connection with their dealings with problem employees as well as to provide direct

counseling to employees. Based on the supervisor's documentation of declining work performance, attendance problems, disruptive behavior, etc., the medical department can become acquainted with the case history and be prepared to offer guidance to the supervisor and, when requested, counseling to the employee. In order to develop this kind of cooperative effort, clear working relationships should be spelled out for the medical department and supervisors concerned with employees with performance problems.*

Because alcoholism and problem drinking represent a unique illness, the medical staff should be provided with specialized training for recognition of alcohol abuse as well as instruction in counseling techniques appropriate for use in dealing with the problem drinker or the alcoholic.

VII. Relationship to Disciplinary Actions

The alcoholism program supplements, but does not replace, existing procedures for dealing with problem employees.

Its premise is that one type of problem employee is the alcoholic or problem drinker and that, in the case of this particular type of problem employee, a special situation exists. The employee is a problem because of repeated instances of uncontrollable drinking. The drinking he does is either an illness or a symptom of an illness and, as with other types of illnesses, it must be the agency's policy to try to assist him to recover his usefulness as an employee.

In practice the alcoholic or problem drinker should be dealt with little differently from other problem employees. The supervisor identifies the aspects of job performance that are not satisfactory, consults with the medical and/or counseling staff those cases that appear to be developing a trend, discusses aspects of below standard performance with the employee and advises him of availability of counseling assistance if the cause of poor performance stems from any personal problem. If the employee refuses to seek counseling and/or if there is no improvement or inadequate improvement in performance, disciplinary actions should be taken, as warranted, solely on the basis of unsatisfactory job performance.

In relating the alcoholism program to disciplinary policies and practices, it is most important that the alcoholism program be carried out as a nondisciplinary procedure aimed at rehabilitation of persons who suffer from a disease. There needs to be a clear understanding that shielding problem drinkers by tolerating poor performance clearly contributes to the progression of the employee's illness by delaying his entry into a rehabilitative program. However, failure on the part of the employee to

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* The Commission recognizes that many small agencies lack the medical facilities to comply with this proposal. Where no local agency medical capability exists, agency program officials should seek the services of a neighboring Federal agency facility or community resource.

accept the assistance offered through the program or to otherwise correct performance should be dealt with through disciplinary procedures.

VIII. Records and Reports

1. Maintenance of Records on Individuals

General supervisory documentation of employee job performance and actions taken to motivate correction of job deficiencies should be maintained, as with all employee records, in a strictly confidential manner. The responsibility for developing a responsive and useful job performance documentation system rests with agency officials.

Records on employees who have been referred for counseling, whether by medical, personnel, or other counseling specialists, should be maintained in the strictest confidence and accorded the same security and accessibility restrictions provided for medical records.

Records containing medical information and reports must be maintained according to requirements prescribed in FPM chapter 293, subchapter 3-3.

Official Personnel Folders shall not include information concerning an employee's alcohol problems or efforts to rehabilitate him except as they apply to specific charges leading to disciplinary or separation actions.

2. Statistical Reports

Agency Program Administrators should compile sufficient statistical data to provide the basis for evaluating the extent of alcoholism problems and the effectiveness of the counseling program. Reports will be prepared and submitted to agency management on a regular basis; a report will also be submitted to the Civil Service Commission annually.

The report to the Commission will include for each fiscal year beginning with Fiscal Year 1972: (1) the number of employees counseled by medical, personnel, or other counseling specialists where the counselor concluded that problem drinking was an issue and (2) the number of employees identified as having been helped through the alcoholism program. Instructions for reporting will be issued annually via a CSC Bulletin. The reports will be due on August 15, 1972, and on the same date each year thereafter. Reports will be submitted to:

U.S. Civil Service Commission
Bureau of Retirement, Insurance,
and Occupational Health
Occupational Health Division
Washington, D. C. 20415

Care should be taken that such records are purely statistical and do not identify individuals.

IX. Use of Sick Leave

A critical and necessary step is recognition by an individual with a drinking problem that alcoholism is a treatable disease. Employees who have made the decision to undergo a prescribed program of treatment which will require absence from work should be granted sick leave for this purpose.

X. Expenses of Rehabilitation

There is no provision in P.L. 91-616 for payment of Federal employee rehabilitation costs. An employee is responsible for the costs of treating his drinking problem just as he is for any other health condition. He may receive some financial help, as with other illnesses, from his Federal Employees Health Benefits Plan.

Various types of rehabilitative programs require different financial capabilities. Alcoholics Anonymous, for example, solicits only voluntary contributions, hence is freely available; employees who are veterans may be eligible for some assistance from the facilities of the Veterans Administration. Eligibility requirements and costs of alcohol rehabilitation agencies in the community should be explored by the Program Coordinator in order to have available complete information for counseling and employee referral purposes.

XI. Eligibility for Disability Retirement

This program does not jeopardize the employee's right to disability retirement if his condition warrants. Eligibility requirements and filing procedures are in FPM Supplement 831-1. Either the employee or the agency may submit an application for disability retirement.

XII. Employment Considerations

Section 201 (c)(1) of Public Law 91-616 states:

> "No person may be denied or deprived of Federal civilian employment or a Federal professional or other license or right solely on the grounds of prior alcohol abuse or prior alcoholism."

In considering applicants for Federal employment who have a history of alcoholism or problem drinking, the Commission will make its determination on the basis of whether or not the applicant is a good employment risk. In such cases the length of time since the last abuse of alcohol is less important than the steps taken by the applicant to secure treatment of his illness through medical care, rehabilitation and similar actions.

However, the foregoing does not apply to the limitations imposed by section 201(c)(2) of Public Law 91-616 which deals with sensitive positions and employment in agencies designated for purposes of national security by the President.

XIII. Acknowledgements and Recommended Source Material

This guide was developed using information derived from THE FIRST STEP, a publication by the Civil Service Commission which reported the proceedings of a conference dealing with drinking problems held in late 1967. The guide also incorporates many of the concepts embodied in THE KEY STEP, a Civil Service Commission publication which offered to Federal managers a model program to combat problem drinking. This FPM Letter replaces THE KEY STEP.

Special acknowledgement is due the American Medical Association, the National Council on Alcoholism, and the National Industrial Conference Board. These organizations granted our requests for permission to draw material from their publications in the development of these guidelines. The specific issuances are strongly recommended as reference sources for development of agency programs. They are:

1. Manual on Alcoholism -- 1967 (Available from the American Medical Association, 535 N. Dearborn Street, Chicago, Illinois 60610)

2. A Cooperative Labor-Management Approach to Employee Alcoholism Programs (Available from the National Council on Alcoholism, 2 Park Avenue, New York, New York 10016)

3. Company Controls for Drinking Problems (Available from the National Industrial Conference Board, 845 Third Avenue, New York, New York 10022)

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FPM LTR. NO. 792-5

UNITED STATES CIVIL SERVICE COMMISSION

FEDERAL PERSONNEL MANUAL SYSTEM

LETTER

FPM LETTER NO. 792-5

Washington, D.C. 20415
July 19, 1971

SUBJECT: **Federal Employee Occupational Health Programs; Safeguarding Privacy of Participants**

Heads of Departments and Independent Establishments:

The Civil Service Commission is charged with the responsibility for assisting agencies in developing adequate programs of occupational health services. Our experience has been that bringing traditional health clinic services to small concentrations of employees is usually uneconomical, but that opportunities do exist for providing limited health services in these situations.

Among these are private organizations or individuals that offer health screening packages which typically include use of a family history questionnaire. The content of some questionnaires is such that safeguards must be taken to insure that there is no overt or covert invasion of privacy of participants.

The purpose of this letter is to instruct Federal agencies that obtain these kinds of services for their employees that they must provide notification to their employees (1) that their participation is strictly voluntary in that no official request to participate will be made but, instead, employees will be offered the opportunity to participate at their own election; (2) that completion of any questionnaire or of any particular question is entirely optional on the part of each individual employee; and (3) that the collecting, processing, and final disposition of medical specimens and information will be safeguarded to insure that only the employee and the employee's physician are apprised of the results via professional medical channels, and that no individual employee medical findings resulting from such services will be made available to agency personnel, management or supervisory officials.

INQUIRIES: Regional Office or Bureau of Retirement, Insurance, and Occupational Health, Occupational Health Division, 63-25532 or Code 101, ext. 25532
CSC CODE 792- Health Program

DISTRIBUTION: FPM

These same protections must also be afforded employees participating in preventive or disease detection programs at agency or contractor operated occupational health facilities.

Bernard Rosen

Bernard Rosen
Executive Director

NATIONAL ORGANIZATIONS CONCERNED WITH OCCUPATIONAL HEALTH

American Association of Industrial Nurses, Inc. (AAIN)
79 Madison Avenue
New York, N.Y. 10016

American Cancer Society
219 East 42nd Street
New York, N.Y. 10017

American Conference of Governmental Industrial Hygienists (ACGIH)
1014 Broadway
Cincinnati, Ohio 45202

American Heart Association
44 East 23rd Street
New York, N.Y. 10010

American Industrial Hygiene Association (AIHA)
25711 Southfield Road
Southfield, Mich. 48075

American Medical Association (AMA)
535 North Dearborn Street
Chicago, Ill. 60610
Attn: Dept. of Occupational Health

American National Red Cross
17th and D Streets, N.W.
Washington, D.C. 20006

American National Standards Institute (ANSI)
10 East 40th Street
New York, N.Y. 10016

American Nurses Association (ANA)
10 Columbus Circle
New York, N.Y. 10019

American Public Health Association
1790 Broadway
New York, N.Y. 10019

Industrial Health Foundation (IHF)
5231 Centre Avenue
Pittsburgh, Pa. 15232

Industrial Medical Association (IMA)
150 North Wacker Drive
Chicago, Ill. 60606

National Association of Manufacturers (NAM)
2 East 48th Street
New York, N.Y. 10017

National Committee on Alcoholism
2 East 103rd Street
New York, N.Y. 10029

National Institute for Occupational Safety and Health (NIOSH)
1014 Broadway
Cincinnati, Ohio 45202

National League for Nursing (NLN)
10 Columbus Circle
New York, N.Y. 10019

National Safety Council
452 North Michigan Avenue
Chicago, Ill. 60611

National Society for the Prevention of Blindness
29 Madison Avenue
New York, N.Y. 10016

National Tuberculosis and Respiratory Disease Association
1740 Broadway
New York, N.Y. 10019

Occupational Health Institute, Inc.
(nonprofit educational organization created by IMA)
150 North Wacker Drive
Chicago, Ill. 60606

Recovery, Inc.
116 South Michigan Avenue
Chicago, Ill. 60603

OCCUPATIONAL HEALTH MANUAL

U.S. Department of Labor
14th Street & Constitution Avenue, N.W.
Washington, D.C. 20210

U.S. Government Printing Office (GPO)
Superintendent of Documents
Washington, D.C. 20402

INDEX

Allergic reaction(s)
  dermatitis, 44
  record, 7
American Conference of Governmental Industrial Hygienists (ACGIH), 45, 187
AMA Council of Occupational Health, 2, 187
Anemia, 38
Angina, 40
Aphakia, 46
Arterial graft, 40
Audiogram(s), 31, 47
Audiometric examination, 47
A-V block, 40

BEC (Bureau of Employment Compensation) Forms, 79-91
  See also Compensation Forms,
Benzene, 44
Bureau of Federal Employees' Compensation, 8, 9
Burns
  alkali, 60
  phenol, cresol and tar, 60
  white phosphorus, 60

Carbon tetrachloride, 44
Cardiac conditions
  A-V block, 40
  evaluation of, 32
  followup form, 115
  post-physical recommendations, 35
  cor pulmonale, 40
Civil Service Commission, 10
  CSC forms, 104
Compensation forms, 18, 79
  Notice of injury (CA 1 & 2), 84
    preparation of, 18
  Notice of recurrence of disability (CA-2a), 88
    preparation of, 19
  Preparing/filing of, 18
  Referral (CA-16), 90
    preparation of, 18
Conjunctivitis, 38
Contact lens use, 46
Contusion, 71
Copper sulfate solution, 59
Cor pulmonale, 40
Cyanide (CN), 39

Death, general procedures for, 75
Dermatitis, 38
  as allergic reaction, 44
  treatment of, 61
Detection of emotional problems, 76
Diabetes
  evaluation of, 32
  followup form, 115
  post-physical recommendations, 35
Disability retirement, 37
  eligibility requirements, 40
  examinations, 37

Emergency procedures, 52
  bleeding control, 53
  care of unconscious patient, 55
  prevention of wound infection, 54
  resuscitation, 53
  shock prevention and treatment, 54
Emphysema, 40
Employment of the handicapped
  criteria, 48
Environmental hazards, 44

Epilepsy
  evaluation of, 35
  medical report form (CSC 739), 106
Examination
  audiometric, 47
  neurological, 39
  physical, 32
  sobriety, 41
  special-fitness, 40
Eye care, (in hazard area), 46
Eye injuries, 63
  chemical burns, 63
  contusions, 65
  foreign body in, 66
  herpes zoster ophthalmicus, 67
  inflammation, 67
  infrared, laser, or microwave burns, 64
  laceration, 67

pain in, 65
penetration, perforation or rupture, 67
thermal burns, 64
ultraviolet burns, 65

Federal Employees' Compensation Act, 2
Federal Personnel Manual, 2, 43, 129
Chapter 792, 133
Letters and attachments, 140
Selected chapter titles, 129
Fibrillation, chronic, 40
Forms, 79
BEC, 79
Civil Service, 104
local, 114
other, 111
standard (SF), 92
Fracture or dislocation, 72

Handicap(s),
code, 20
mental, definition of, 48
Harmful substances, 44
Hazardous materials, 38
amatol, 38
ammonium picrate, 38
anthracite, 39
asbestos, 39
dust, 39
hexamethylene tetranitramine, 38
lead
manganese
mercury, 38
metal fumes
missile fuels, 38
missile fuel oxidizers, 38
pitches and tar, 39
pyro compounds, 38
radiation, 39
RDX, 38
silica, 39
trichloroethylene, 39
TNT, 38
ultraviolet light, 39

Hazardous occupations,
health evaluations, 36
list of, 38, 39
Hearing Conservation Program, 47
Hip prosthesis, 40

Immunization(s), 43
diptheria, 43
record (SF 601), 7, 18
tetanus, 7, 43, 75
influenza, 43
smallpox, 43
Industrial hygienist, 7,
Injections, 76

Knee injuries, 40

Laboratory technician(s), 3
Liver damage, 38
Local forms, 114

Medical equipment for OH clinic, 5
Medical examination
certificate (SF 78) of, 17
in health record, 17
Medical history, report of (Optional Form, 58, 18
Medical followup card(s), 118
preparation of, 19
Medical record jacket (DD-722), 17
placement of forms in, 17, 18
Medical record log, (civilian employees), 15, 16, 17
code for, 17
preparation of, 15
Menstrual disorders, 42

National Society for the Prevention of Blindness, 46, 187
Navy Industrial Environment Health Center, 7, 10
Nervous or mental disorder, evaluation of, 34
Neurological examination, 39

Noise
attenuation, 48
measurement, 48

Occupational health clinic
construction authority, 4
facilities planning, 3
layout, 3
staff requirements, 3
services, 6
medical equipment, 5
space requirements, 3
Occupational health nurse, 3, 21
administrative/supervisory duties, 21
general nursing, 21
health evaluations, 24
Occupational health physician,
emergency care duties, 26
care of dependents and retirees, 29
consulting with the Safety Department, 28
reporting, 28
recording clinical data, 28
treatment of occupational conditions, 27
humanitarian treatment, 27
for compensation cases, 27
work environment orientation duties, 26
Occupational Safety and Health Administration (OSHA), 75
Office of Federal Employee Compensation (OFEC), 74

Physical examination(s), 29
abnormal findings, 30
fitness-for-duty examinations, 37
of applicants for light duty work, 29
pre-hire examinations, 30
periodic health evaluations, 36
report, 32
Physically unqualified employees, 50
Physician approval of standing orders, 52
Physiotherapy, 76
equipment, 5
Post-physical recommendations, 35
Pregnancy
in working women, 41
letter to attending physician, 118
Procedures, general, for
death, 75
serious injury, 75
Occupational and/or nonoccupational disorders, 74
Physical examination report, 32
Public Health Service, 11

Reception and records clerk, 3, 13
duties, 14
Records, medical
applicants not employed, 19
maintenance, 15
medical, 14
log, 15, 16, 17
preparation of, 15
Repeat audiogram log, 20
Reports,
Confidential medical, 20
Monthly and quarterly, 19
Retinal detachment, precaution against, 46

Safety Department role, 10
Serious injury, general procedures for, 75
Sight Conservation Program, 45, 35
Silica, 44
Sodium bicarbonate, 58
Sprain, 72
Standard forms (SF)
application for leave (SF 71-109), 8, 101
certificate of medical examination (SF 78), 32
report of medical history (SF 93), 32
Strain, 71
Standing orders
See Treatment, first aid,
Stokes - Adams syndrome, 40

Tests
blood glucose determination, 43
cholinesterase determination, 39
frequency of, 39

hematocrit, 30
tonometry, 43
urinalysis, 30
vision, 43
Treatment(s), convenience, 75
injections, 76
physiotherapy, 76
Treatment, first aid
abrasions, 55
bite(s)
animal, 56
insect, 56
snake, 58
bleeding, 53
burns
chemical, 59
eye, of the, 63
thermal, 58
cardiac emergencies, 60
dermatitis, 61
dysmenorrhea, 61
ear problems, 62
earache, 62
eye injuries, 63
burns, 63
contusion, 65
foreign body in eye, 66
pain, 65
fever, 68
headache, 68
heat cramps, 69
heat disorders, 68
heat exhaustion, 69
heat prostration, 69
heat rash, 68
heat stroke, 70
lacerations, 70
live insect in ear canal, 67
musculoskeletal injuries, 71
nosebleed, 73
respiratory infection, 73
shock, 54
skin problems, 61
toothache, 74
wound infection, 54
unconscious patient, 55
Tuberculosis, pulmonary
evaluation of, 35
medical report form (CSC 4434), 108

Uranium, 44

Vision tests, 43

Working women
lifting limits for, 41
pregnancy in, 41
Workmen's Compensation
computation of benefits, 49

X-ray(s)
in checkups, 43
technician(s), 3

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